THE DISTRICT OF COLUMBIA

HEALTHY PEOPLE 2010 PLAN

MID-COURSE REVISIONS 2000-2005

Government of the
District of Columbia
Anthony A. Williams, Mayor

D.C. Department of Health
Dr. Gregg A. Pane, Director

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Gregg A. Pane, Director of Department of Health

FOREWORD

I am pleased to introduce the Department of Health's Mid-Course Revisions to the District of Columbia Healthy People 2010 Plan. As in the federal plan, the overarching goals of the District are to extend the years of healthy life and eliminate disparities.

The purpose of this document is to restate our commitment to the attainment of these broad goals with 2010 objectives that have been updated with baselines closer to 2000, and in some cases reformulated. A few objectives have been deleted, due to changes in program priorities.

This document also should serve as an invitation to health care providers and community-based health promoters to join in partnership with us at the Department of Health to connect residents with risk-reduction strategies and available services that will increase their chances, and those of their families, for a long and productive life.

Please join me in promoting the DC Healthy People 2010 strategies to local professional and lay audiences interested in a better quality of life for all who reside in the District of Columbia.

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ACKNOWLEDGEMENTS

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TABLE OF CONTENTS

HEALTHY PEOPLE 2010 PRIORITY AREAS

INTRODUCTION

WHAT IS THE HEALTHY PEOPLE 2010 PLAN?

In a recent presentation, Dr. David Satcher, the former US Surgeon General, described "Healthy People" as:

- "A comprehensive set of national 10-year health objectives
- Developed by a collaborative process
- Designed to measure progress over time
- A public health document that is part strategic plan, part national health data report, and part textbook on public health priorities."

The HEALTHY PEOPLE 2010 planning process is a national effort to address the major threats to good health and long life for all Americans. The process sets the disease prevention planning agenda for the nation. It aims to inspire state health agencies to develop similar plans within their jurisdictions to improve the health status of the community.

The HEALTHY PEOPLE 2010 PLAN for the nation differs from previous disease prevention and health promotion campaigns announced by the Surgeon General in that it is more inclusive of racial and ethnic minority populations. For the major diseases addressed in the Plan, the same target is set for all, but baselines are defined according to each of the resident minority population groups. The Plan recognizes disparities in disease outcomes - compared to the white majority - among the various population groups that are attributable to a combination of factors including race and ethnicity, gender, age, socioeconomic status, educational attainment, and other variables. Its overarching goals are to extend the years of healthy life and to eliminate health disparities between white Americans and Americans of minority origin by 2010.

The Department of Health (DOH) is responsible for recognizing and serving the health needs of District of Columbia (DC) residents. It sets the agenda for providing disease prevention and health promotion services to local residents, whose needs may or may not coincide with those of people residing in other communities. Even within the city, the health needs of the diverse population subgroups of residents are similar in some instances and divergent in other instances. Consequently, meeting the health needs of diverse populations among District residents may require a variety of measurable, culturally sensitive, and cost-effective disease prevention and control activities. The DC Healthy People 2010 Plan presents the proposed strategies for closing the gaps in health status among residents.

The purpose of this document is to present a revised version of the DC Healthy People 2010 Plan released in 2000. This version of the 2010 Plan contains updated information in the form of revised baselines and a new overview for each chapter which, as in the federal plan, will provide more detailed information related issues and trends, disparities, and opportunities.

The mission of the DOH is to ensure a safe and healthy environment for city residents. This mission drives its development of the District's Healthy People 2010 Plan which includes the following focus areas:

- Asthma;
- Cancer;
- Cardiovacular Disease (formerly Heart Disease and Stroke);
- Diabetes;
- Disabilities;
- Emergency Medical Services;
- Environmental Health and Food Safety;
- Health Care Finance;
- HIV/AIDS;
- Immunization and Infectious Diseases;
- Injury/Violence Prevention;
- Maternal, Infant, and Child Health and Family Planning;
- Mental Health and Mental Disorders;
- Nutrition;
- Pediatric Dental Health;
- Primary Care;
- Public Health Infrastructure;
- Sexually Transmitted Diseases;
- Substance Abuse;
- Tobacco Use; and
- Tuberculosis.

The goals and objectives in the twenty-one focus areas addressed in this document are grouped according to the four federal and DC Healthy People 2010 Plan Priorities:

- Promote Healthy Behaviors;
- Promote Healthy and Safe Communities;
- Improve Access to Quality Health Care Services; and
- Prevent and Reduce Diseases and Disorders.

The Leading Health Indicators – selected in a process of regional and national meetings for their ability to motivate action, the availability of data to measure progress, and their relevance to broad public issues – are noted in the corresponding focus areas and addressed in the District of Columbia Chart Book that soon will be available online.

PLANNING PROCESS

The development of the District's Plan was coordinated by the State Center for Health Statistics Administration. Public comment was solicited throughout the planning.

The planning process includes the following steps:

1. Area Profile and Analysis
   - Analyze demographic and socioeconomic data;
   - Review health status data; and
   - Review existing needs.

2. Analysis of Federal Guidelines and State Categorical Health Plans and Existing Policies
   - Review federal HEALTHY PEOPLE 2010 PLAN policies and procedures;
   - Review District state plans and policies;
   - Establish planning group with work group and program liaisons; and
   - Conduct status review of the 1993 Healthy Residents 2000 Plan for the District.

3. Community Participation
   - Establish committees and advisory groups;
   - Convene public hearings;
   - Receive written comments; and
   - Review suggested revisions and sanction certain changes.

4. Plan Implementation
   - Develop strategies;
   - Develop an annual implementation plan; and

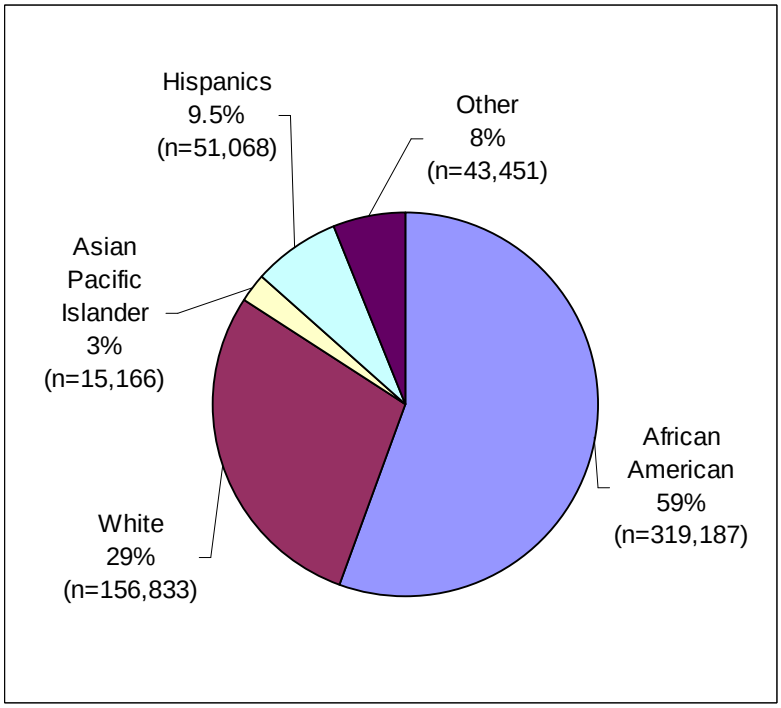
5. Monitor and Evaluate Implementation Activities
   - Plan approval by each of the Focus Area Program Administrators.
   - Plan approval by the responsible Deputy Directors;
   - Plan release by the Director of the Department of Health;
   - Plan submission to the mayor; and
   - Plan submission to the U.S. Department of Health and Human Services.

Calendar year 1997 was the baseline year for data in the original DC Healthy People 2010 Plan that was released in 2000. This document presents updated baselines to facilitate midcourse progress evaluation as the year 2010 approaches.

COMMUNITY PROFILE

As the nation's capital, the District of Columbia is characterized by a distinctive international stature and a diverse population. In its 63 square miles, the District is home to a population which represents many world cultures. The 2002 Census indicates that the District's population of 572,059 is 59 percent African American, 29 percent white, 3 percent Asian/ Pacific Islander, and 8 percent Other (Figure 1). Residents of Hispanics ethnicity represent 9.5 percent of the total population. The challenge faced by the District's health system is to address the needs of all its residents, while recognizing the diverse health needs and health status of its numerous subpopulations.

Figure 1: Estimated Population by Race District of Columbia, 2002
2002 Population: 572,059



Source: US Census Bureau, DC Department of Health,
State Center for Health Statistics Administration.

In recent years, dramatic changes, in particular the advent of health care management organizations (HMOs), have occurred in the health care arena. These changes have affected the delivery of health care and created new challenges for shaping public health policy. Nevertheless, the purpose for providing health care has not changed. There remains the need to continuously assess the impact of these changes on public health, on ensuring access to appropriate interventions, on monitoring the overall health system, and on developing appropriate public policy.

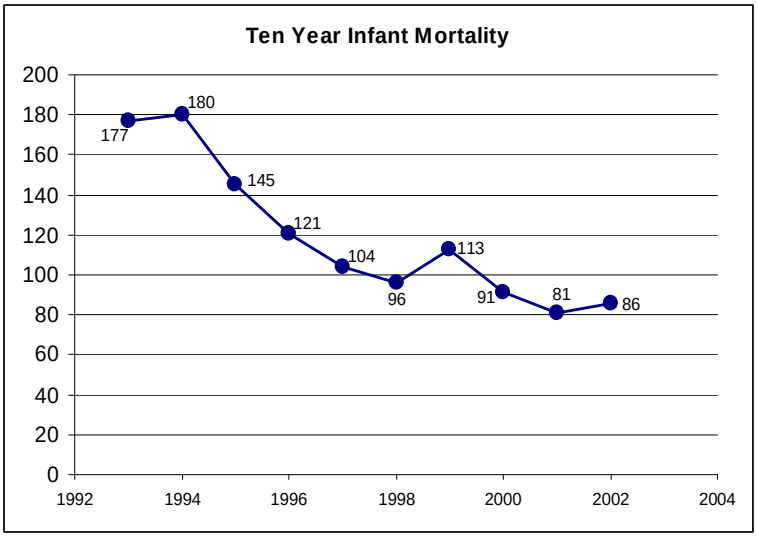
In the midst of this changing health care environment, the District of Columbia struggles with a number of health-related problems among its residents. The five leading causes of death in 2002 were heart disease, cancer, hypertension, cerebrovascular diseases, and homicide. Expressed in crude rates, these deaths occurred at rates of 244.6, 222.9, 61.4, 40.2 and 38.5, respectively. The infant mortality rate in 2002 was 11.5 per 1,000 live births compared with 7.2 nationally. Over the past ten years (1993-2002), there has been an overall declining trend in the infant mortality rate (Table 1 and Figure 2). There were 91 fewer infant deaths in 2002 compared to 1993, representing a decline of 51.4 percent.

Table 1: Ten-Year Infant Mortality Trends for Residents, District of Columbia, 1993-2002

Year	Births	Infant Deaths	Infant Mortality Rate (per 1,000 live births)
1993	10,614	177	16.7
1994	9,911	180	18.2
1995	8,993	145	16.1
1996	8,377	121	14.4
1997	7,916	104	13.1
1998	7,678	96	12.5
1999	7,513	113	15.0
2000	7,666	91	11.9
2001	7,621	81	10.6
2002	7,494	86	11.5

Source: DC Department of Health, State Center for Health Statistics Administration

Figure 2: Ten-Year Infant Mortality Trend, District of Columbia, 1993-2002 (Infant deaths over time)



Source: DC Department of Health, State Center for Health Statistics Administration

An important measure of the health of a given population is the number of premature deaths. If 65 years is used as the age for deaths due to natural causes in the District, then 38 percent of all deaths in the District in 2002 could be regarded as premature (deaths occurring before age 65). The leading causes of premature death were cancer, heart disease, HIV/AIDS, and homicide. Furthermore, to quantify the impact of premature deaths, epidemiologists have employed the measure of "years of potential life lost" (YPLL).

This measure aggregates the difference between the actual age at death and the age of natural death for all deaths. For the District of Columbia, the YPLL for 2002 was 64,171 years which translates into a YPLL rate of 12,815.4 per 100,000 population.

Improving the health of District residents depends on identifying risks to health, adopting Healthy behaviors and lifestyles, and using health services effectively. To reduce risks to health, the community must be protected from communicable diseases and environmental threats Furthermore, in-depth analysis of health data indicates that health problems occur in disproportionate numbers according to gender, race, and socioeconomic status. For example, in 2002, the death rates from the leading cause of mortality in the District were significantly higher for black residents than for white residents; for heart disease the crude death rate was 318.3 per 100,000 for blacks versus 150.1 deaths per 100,000 for whites; for cancer, the rate was 292.1 deaths per 100,000 for blacks versus 129.8 per 100,000 for whites. Thus, the goal of reducing or eliminating health disparities among ethnic groups is particularly important in the District of Columbia.

HEALTH STATUS OF RESIDENTS

The health status of a community is measured by key health status indicators. Taken together with demographic and socioeconomic data, health status indicators provide a profile of the community and are the foundation for defining the community's health needs and assessing the manner in which the health care system can meet those needs (Table 2).

The adequacy of health status measures is predicated on a clear and concise definition of health. It is necessary to know what is to be measured, in order to choose the correct tools with which to measure. The World Health Organization (WHO) has defined health as " a state of complete physical, mental and social well-being." A more generally applied concept

Health Status Indicators addressed in the Data Sheets that have been produced annually by the State Center for distribution to the public are listed in Table 2.

Table 2: Health Status Indicators, District of Columbia, 2002

Indicators	Indicators
1. Census Population: 572,059	10. Total Deaths: 5,779
2. Percent Population 65 year and over:12.2	11. Crude Death Rate per 100,000 population: 1,010.2
3. Live Births: 7,494	12. Infant Deaths: 86
4. Live Birth Rate per 1,000 population: 13.1	13. Infant Mortality Rate per 100,000 population:11.5
5. Low Weight Live Births: 866	14. Heart Disease Death Rate per 100,000 population: 244.6
6. Births to Teenage Mothers: 956	15. Cancer Death Rate per 100,000 population: 222.9
7. Births to Unmarried Women: 4,233	16. Hypertension Death Rate per 100,000 population: 61.4
8. Marriage Rate per 1,000 population: 5.3	17. Cerebrovascular Diseases Death Rate per 100,000 population: 40.2
9. Divorce Rate per 1,000 population: 2.4	18. Homicide Death Rate per 100,000 population: 38.5

Source: Department of Health, State Center for Health Statistics Administration

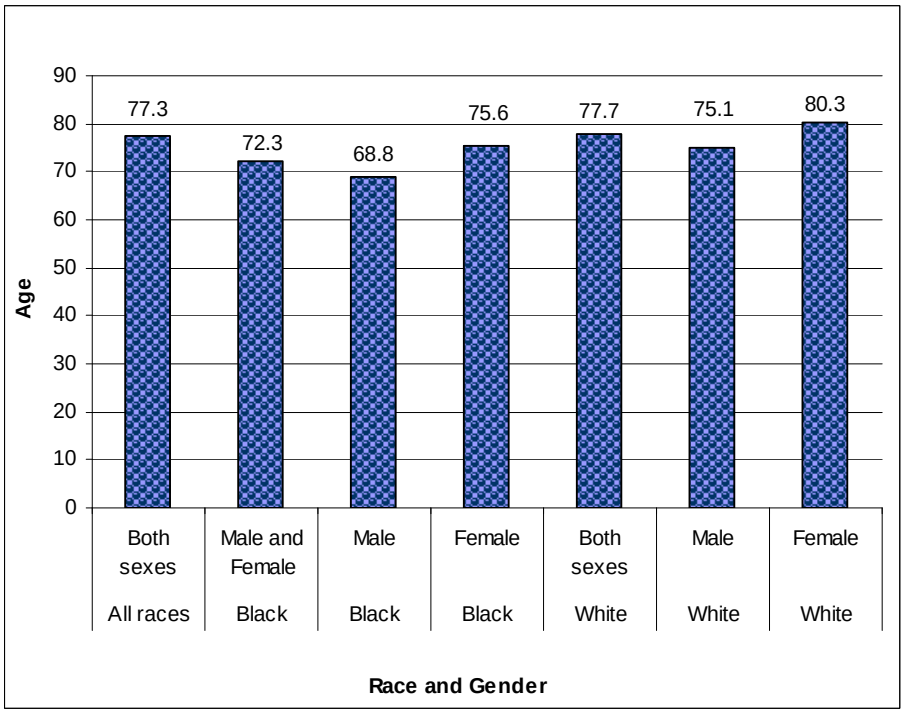
Even though measurements of illness, disease and disability are more accessible than measurements of well-being, problems exist with the availability, validity and reliability of data. Inconsistencies are common in the reporting and recording of illness and disease. Only those diseases are reported that the law requires be reported.

The description given in the 2010 Plan of the health status of District residents is a composite of the available quantifiable measures of life expectancy, natality, mortality and morbidity. Other measures include disability, subjective self-reported assessments of health, selected indicators of lifestyle, and environmental influences. It is important to emphasize the cultural and ethnic diversity of residents of the District of Columbia. Residents represent many racial and ethnic groups that extend beyond the black and white classifications characteristic of many data presentations. Data on the Hispanic population is particularly difficult to obtain, because of the lack of Hispanic identifiers on data collection forms, inappropriate interpretation when Hispanic identifiers are used, and the variety of Spanish-speaking countries of origin of Hispanic residents. In this chapter, data identified with the Hispanic population will be used whenever available in describing the health needs of all District residents.

I. Life Expectancy

As a health status indicator, life expectancy at birth is a comparative measure of longevity. Subjecting the reported number of births in a given time period to age-specific mortality rates yields life expectancy. In 2002, the average life expectancy at birth for the United States was 77.3 years (Table 3), which represents a record high.

Table 3: Life Expectancy at Birth by Race, United States, Age in Years, 2002



Source: National Center for Health Statistics, National Vital Statistics Reports, United States Life Tables, 2002

There are marked differences in life expectancy at birth by race and gender for the total population of the U.S., with females tending to live longer than males and white persons living longer than black persons. For the U.S. as a whole, life expectancy for whites in 2002 was 77.7 years or 5.4 years longer than for the black population. In 2002, life expectancy at birth for males was 74.5 years and for females 79.9 years or 5.4 years longer than for males.

Life expectancy for whites is higher than for blacks. In 2002, life expectancy for black males in the United States was 68.8 years. The life expectancy for black females in the United States was 75.6 years in 2002. In 2002, the life expectancy for white's males was 75.1 years and for white females it was 80.3 years.

II. Natality

Natality data for the District are described in two categories: Births and birth rates and fertility rates.

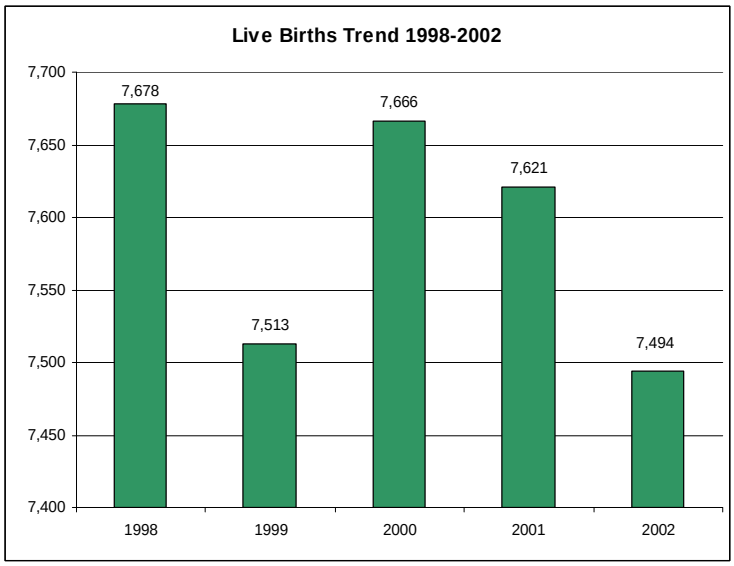
A. Birth and Birth Rates

During the 1990s in the District of Columbia, there was a decrease in the number of live births and the birth rates, after increases in the 1980s. By 2002, the number of resident live births was 7,494, a 19 percent decrease in the number of live births recorded in 1980.

In 1990, the birth rate was 19.5 live births per 1,000 population, up from 14.5 live births per 1,000 in 1980. By 1998, however, the birth rate decreased to 14.7. A similar decline occurred around the nation (NCHS).

In 2002, births to residents of the District of Columbia totaled 7,494 (Figure 3). This figure represents a 35.2 percent decrease over births in 1989 and a 5.3 percent decrease over 1997 (SCHSA). While the number of live births increased steadily from 1980 to 1990, a slight declining trend was noted from 1991 through 1998, with 3,972 fewer births in 1998 than in 1991, a 34.1 percent reduction (SCHSA).

Figure 3: Number of Births, 1998-2002, District of Columbia



Source: Department of Health, State Center for Health Statistics Administration

In 1980, in the United States, there were 307,163 births to Hispanic women. By 1992, that number had more than doubled to 643, 271 (NCHS). The comparable numbers for the District of Columbia were not available for those early years, since the District was not collecting data on Hispanic births. In mid-year1989, however, the District began collecting data on Hispanic births; there were 809 Hispanic births. In 1990 there were 941 births to Hispanic women; in 1992, there were 920. In 1994,

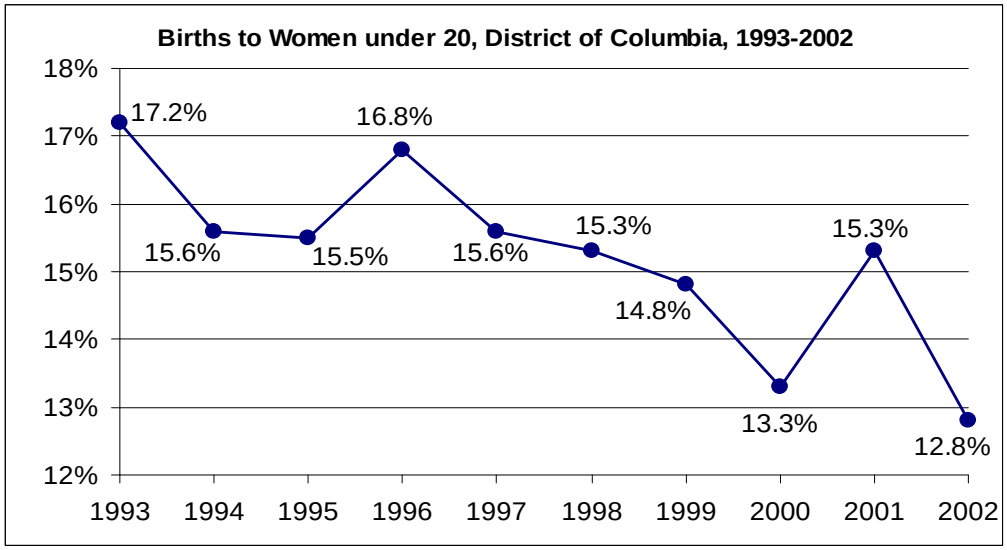
there were 886, and in 1995, there were 715, representing a decline evident over the period of six years. Between 1996 and 2002, the number of births to Hispanic women fluctuated from 853 in 1996 to 646 in 1997 to 762 in 1998 to 842 in 1999 to 1,010 in 2002.

Births to black women who were District residents numbered 5,381 in 1998; 5,081 in 1999; 5,039 in 2000; 4,758 in 2001; and 4,532 in 2002. It appears that there has been a declining trend since 1993. Births to black women continue to decline in the District into the 21st century.

A declining trend could also be noted in births to white women who were District residents. Births totaled 1,442 in 1992; 1,478 in 1993; 1,354 in 1994; 1,422 in 1995; 1,309 in 1996; and 1,300 in 1997. The number of births increased slightly to 1,392 in 1998. Births in the racial category "Other" were fewer than one thousand between 1992 and 1998, except for 1996.

In 1993, births to women under 20 years of age (adolescents) numbered 1,823 representing 17.2 percent of all births. In 1994, there were 1,550 births to teens (15.6 percent); in 1995, there were 1,392 births or 15.5 percent. In 1996, there were 1,406 births to teens or 16.8 percent of all births. In 1997 the number of births to adolescents increased slightly (1,233 or 15.6%). In 1998 the number of births to teens decreased to 1,172 representing 15.6 percent of all births; in 1999 births to teens decreased to 1,113 or 14.8 percent; and in 2000 teen births decreased to 1,086 or 13.3 percent. In 2001 births to teens increased to 1,172 or 15.3 percent of all births. By 2002, the number of births to women under 20 years of age was 956 or 12.8 percent of all births (Table 4).

Table 4: Births to Women Under Age 20, District of Columbia, 1993-2002



Source: Department of Health, State Center for Health Statistics Administration

Births among black adolescents (less than 20 years of age) decreased 9 percent, from 15.6 percent of total live births in 1993 to 14.2 percent in 1994 and 13.5 percent in 1998. Births among white teenagers decreased from 0.4 percent of total live births in 1993 to 0.3 percent in 1994 and 0.2 in 1995 and increased to 0.4 percent in 1998. Single mothers accounted for approximately two-thirds of all births in the District, decreasing from 73 percent in 1993 to 62.8 percent in 1998.

B. Fertility Rates

Another indicator of change in childbearing trends is the fertility rate. The fertility rate is calculated as the number of live births per 1,000 childbearing women aged 15-44 years. Changes in age-specific birth rates and the number of females of childbearing age within an age-specific population have an effect on the projected number of live births during a given time period.

For the U.S. as a whole, the fertility rate declined from 68.4 in 1980 to 65.4 in 1986. After 1986, the rate climbed slightly to 70.9 in 1990. National U.S. data from 1994, 1995, 1996, 1997 and 1998 reflect rates of 66.7, 65.6, 65.0, and 65.6, respectively (NCHS). The District's fertility rate decreased from 68.4 in 1994 to 60.7 in 1998 (SCHSA). The District's population of childbearing women ages 15 to 44 years was estimated to be 126,427 in 1998.

II. Mortality

This section presents information on various aspects of mortality from the District of Columbia Vital Records system. Figures are presented on the total number of deaths, leading causes of death and infant mortality. It shows trends over time and breakdowns by age, gender, race, and ethnicity.

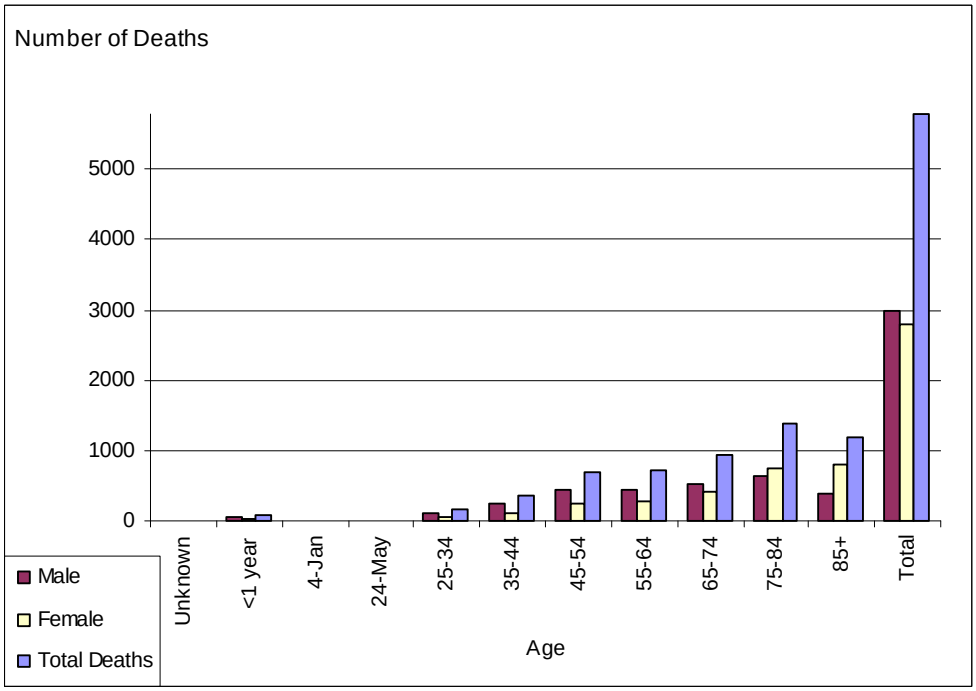
Table 5: Total Deaths by Age and Gender, District of Columbia, 2002

Age Group	Total Deaths	Male	Female
Unknown	4	3	1
<1 year	86	48	38
1-4	6	4	2
5-24	13	6	7
25-34	165	117	48
35-44	366	248	118
45-54	698	441	257
55-64	723	441	282
65-74	937	522	415
75-84	1,391	642	749
85+	1,202	388	814
Total	5,779	2,987	2,792

Source: Department of Health, State Center for Health Statistics Administration

In 2002, there were 5,779 deaths to residents of the District of Columbia (Table 5 and Figure 4). This represents a crude death rate of 1,010.2 per 100,000 population and an age-adjusted rate of 1,0340.4 per 100,000 population. The District's crude death rate is higher than the national rate, but declining since 1994. The 2002 crude death rate for males (1,108.9 per 100,000) was considerably higher than for females (922.4 per 100,000) (Table 6). The 2002 crude death rate for blacks (1,342.5 per 100,000 population) (Table 7) was significantly higher than for whites (625.2 per 100,000) (Table 8). Table 9 presents the 2002 crude death rates for Hispanics.

Fig. 4: Total Deaths by Age and Gender, District of Columbia, 2002



Legend: Males in dark gray (red); females in white; total deaths in light gray (blue).
Source: Department of Health, State Center for Health Statistics Administration

A. Leading Causes of Death

The leading cause of death to the District of Columbia residents in 2002 continued to be heart disease, which accounted for 1,399 or 24.2 percent of all deaths (Figure 5). Cancer remained the second most frequent cause of death to residents, being responsible for 22.1 percent of all deaths in 2002. The third leading cause of death, hypertension, accounted for 6.1 percent of the total deaths. Together, these three causes accounted for 1 of every 2 deaths in 2002 (52.3 percent). Deaths due to cerebrovascular diseases (stroke) ranked fourth in 2002, with 230 (4 percent) resident deaths reported. Homicide was the fifth leading cause of death in 2002 with 220 (3.8 percent) resident deaths reported.

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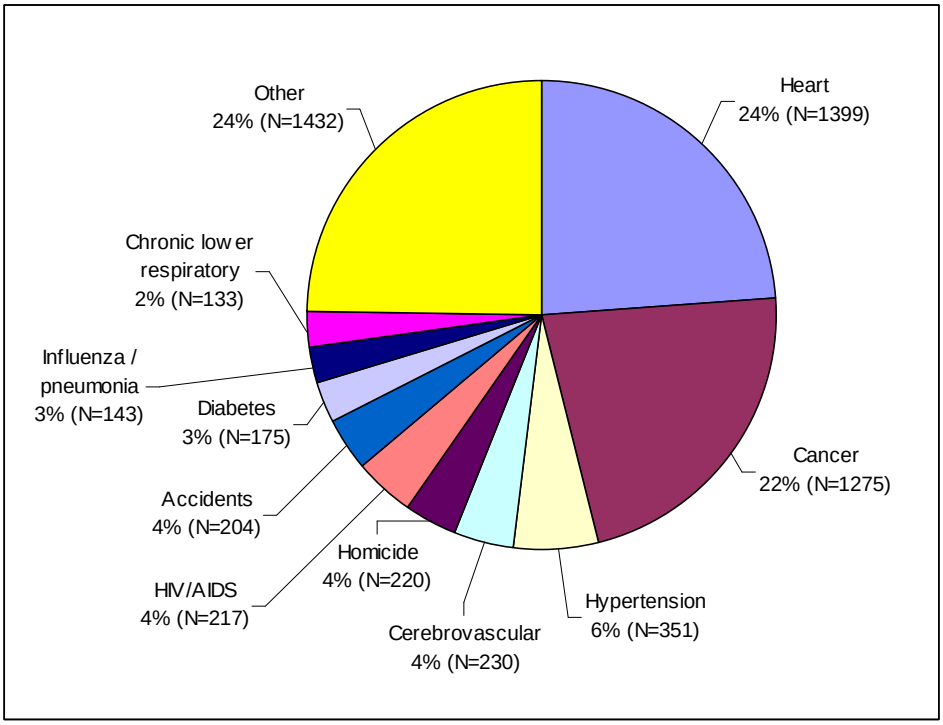
Fig. 5: Top Ten Leading Causes of Death, District of Columbia 2002



Source: Department of Health, State Center for Health Statistics Administration

1. Heart Disease

Heart disease is the leading cause of death in the District of Columbia as it is nationally and a major cause of illness and disability in middle and later life. From 1998 through 2002, there were 7,492 heart disease deaths in the District of Columbia of which 3,413 were males and 4,079 were females. Some variations in heart disease deaths exist among the city wards in the District. Death rates from heart disease have been highest in Wards 4 and 5 and lowest in Wards 8 and 1, consistently from 1998 through 2002.

Although more females than males died of heart disease from 1998 through 2002, male heart disease deaths were on the average twice the number of female heart disease deaths prior to age 65 years. The greater number of female heart disease deaths for the 65 years and older age group is consistent with the higher life expectancy rate of females.

Heart disease deaths viewed by race showed that a disproportionate number of deaths occurred among blacks (75 percent) in comparison to their share of the total population (approximately 60 percent) (Fig 1). Furthermore, the crude death rate for blacks was

318.3 per 100,000 in 2002 (Table 7) but more than twice the white rate of 150.1 deaths per 100,000 population (Table 8).

Table 6: Five Leading Causes of Death by Gender, District of Columbia Residents, 2002

Cause of Death	Total Number	Total Rate	No. of Males	Male Rate	No. of Females	Female Rate
All causes	5,779	1,010.2	2,987	1,112.3	2,792	928.7
1.Heart Disease	1,399	244.6	649	241.7	750	249.5
2. Cancer	1,275	222.9	659	245.4	616	204.9
3. Hypertension	351	61.4	180	67.9	171	56.9
4. Cerebro-vascular Disease	230	40.2	84	31.3	146	48.6
5. Homicide	220	38.5	191	71.1	29	9.6

Source: DC Department of Health, State Center for Health Statistics Administration

Table 7: Five Leading Causes of Death by Race: Blacks, District of Columbia, 2002

Cause of Death	Number of Deaths	Crude Rates (per 100,000 (population)
All Causes	4,609	1,356.0
1. Heart Diseases	1,082	318.3
2. Cancer	993	292.1
3. Hypertension	311	91.5
4. Homicide	207	60.9
5. HIV/AIDS	196	57.7

Source: DC Department of Health, State Center for Health Statistics Administration

Table 8: Five Leading Causes of Death by Race, Whites, District of Columbia, 2002

Cause of Death	Number of Deaths	Crude Rates (per 100,000 pop.)
All Causes	1,101	545.5
1. Heart Diseases	303	150.1
2. Cancer	262	129.8
3. Cerebrovascular Disease	59	29.2
4. Accidents	41	20.3
5. Chronic Lower Respiratory Disease	36	17.8

Source: DC Department of Health, State Center for Health Statistics Administration

Table 9: Five* Leading Causes of Death by Race, Hispanics, District of Columbia, 2002

Cause of Death	Number of Deaths	Crude Rates (per 100,000 population)
All Causes	41	79.9
1. Cancer	6	11.7
2. Diseases of the Heart	5	9.7
2. Accidents	5	9.7
4. Cerebrovascular Diseases	4	7.8
5. Hypertension	3	5.8
5. Atherosclerosis	3	5.8
All Other Causes	15	29.2

(*Only four of five are in large enough numbers to be counted as significant.)
Source: Department of Health, State Center for Health Statistics Administration

2. Cancer

Cancer is a chronic disease, which is the second leading cause of death in both the United States and the District of Columbia. It accounts for one in every five deaths in America and in the District. One in every three Americans alive today will eventually be diagnosed with cancer. In the District of Columbia, over 3,000 new cases of cancer are reported each year. This translates into one of the nation's highest prevalence rates for cancer.

From 1998 through 2002, 6,617 District residents died from cancer of whom 3,350 were males and 3,267 were females. During this same period, approximately 15.766 cases were newly diagnosed among District residents. Cancer affects residents in every city ward.

Ward 4 residents consistently have carried the heaviest burden of cancer deaths compared to other wards. Up to the age of 79 years, a greater number of males died from cancer as compared to females. However, more females than males died of cancer after the age of 80 years, a finding that can be accounted for by the older average life expectancy of women.

The crude rates for cancer showed a fluctuating trend. The crude death rate declined from 258.1 deaths per 100,000 population in 1998 to 222.9 deaths per 100,000 population in 2000.

3. Hypertension

Hypertension has replaced cerebrovascular diseases (stroke) as the third leading cause of death in 2001 and 2002. The hypertension death rate was 57.2 per 100,000 population (5.6%) in 2001, and 61.4 per 100,000 population (6.1%) in 2002. Less than half of the people with hypertension have this condition under control. In the District of Columbia, hypertension is nearly three times as common among African Americans than among whites.

Hypertension is referred to as the "silent killer" because a person may not express physical symptoms while the vascular damage is taking place. It is also, for the most part, a completely modifiable risk factor for cardiovascular disease via diet, exercise, and prescribed medications, if positively diagnosed by a primary care physician.

4. Cerebrovascular Disease (Stroke)

Cerebrovascular disease, also known as stroke, is the second major category of cardiovascular diseases, besides heart disease, and was the fourth leading cause of death for 2002. Cerebrovascular disease or stroke was also the number one cause of disability. Blacks are twice as likely to suffer a stroke as whites. More women die each year from stroke than from breast cancer. However, according to the Stroke Prevention Council, 80 percent of all strokes are preventable. The crude death rate for cerebrovascular disease has been following a consistently fluctuating pattern each year since 1998. In 1998, the cerebrovascular death rate was 57.9 per 100,000 population, while in 2002, it was 40.2 per 100,000 population. The 2001 rate of 39.2 was the lowest over this five-year period.

5. Homicide

The number of homicides to District of Columbia residents decreased from 1998 (218 deaths) through 2000 (174 deaths), then began increasing through 2002 (220 deaths). The homicide rate followed a similar pattern declining from 41.7 per 100,000 population in 1998, 30.4 per 100,000 population in 2000, and rising again to 38.5 per 100,000 population in 2002. The black homicide rate (60.9 per 100,000 population) was eleven times higher than the white homicide rate (5.5 per 100,000 population) in 2002. On average, 94 percent of all homicide victims in the District of Columbia were black for the 1998 through 2002 period.

In 2002, the 20-24 years age group had the highest number of homicides (66 deaths), followed by the 25-29 years age group (35 deaths) and the 15-19 years age group (33 deaths).

B. Other Major Causes of Death – Infant Mortality

In 2002, there were 7,494 live births and 86 infant deaths to District residents. This resulted in an infant mortality rate (IMR) of 11.5 deaths for every 1,000 live births. In 2001, there were 7,621 live births and 81 infant deaths. The infant mortality rate for 2001 was 10.6 deaths per 1,000 live births. Ward 3 had the lowest infant mortality rate at 3.3 deaths per 1,000 live births and Ward 7 had the highest infant mortality rate at 17.1 deaths per 1,000 live births.

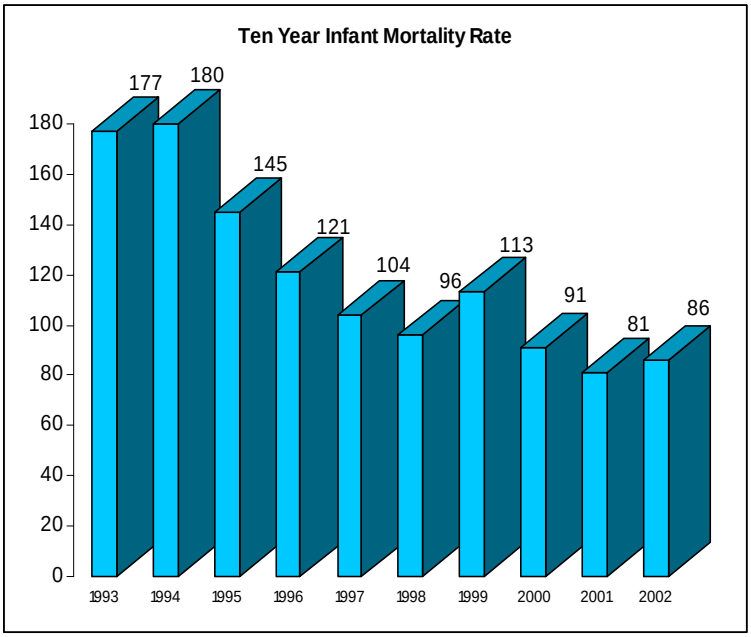
Over the past 10 years (1993-2002) there has been an overall declining trend in IMR as show in Table 10 and Figure 6. During this ten-year of infant deaths declined from 177 in 1993 to 86 in 2002, a 31.1 percent decline. Of the 86 infant deaths that occurred in 2002, 58 (or 67.4 percent) occurred during the neonatal period (under 28 days of life). There was no change in the neonatal death rate between 2001 and 2002 at 7.77 per 1,000 live births. The post neonatal death rate (deaths occurring from 28 days to under one year of age) was 3.7 per 1,000 live births in 2002 compared to 2.9 per 1,000 live births in 2001, an increase of 27.6 percent.

Table 10: Ten-Year Infant Mortality Trends for Residents, District of Columbia, 1993-2002

Year	Births	Infant Deaths	Infant Mortality Rate (per 1,000 live births)
1993	10,614	177	16.7
1994	9,911	180	18.2
1995	8,993	145	16.1
1996	8,377	121	14.4
1997	7,916	104	13.1
1998	7,678	96	12.5
1999	7,513	113	15.0
2000	7,666	91	11.9
2001	7,621	81	10.6
2002	7,494	86	11.5

Source: DC Department of Health, State Center for Health Statistics Administration

Figure 6: Ten-Year Infant Mortality Trend, District of Columbia, 1993-2002



Source: DC Department of Health, State Center for Health Statistics Administration

Vital statistics over the years have indicated that factors such as low birth weight and lack of prenatal care are associated with infant mortality. In 2002, the percentage of low birth weight infants (those weighing under 2,500 grams or 5.5 pounds) in the District was 11.6 compared to 12.2 percent in 2001 (Table 8). The percentage of low birth weight babies born to black mothers decreased from 15.5 in 2001 to 14.6 in 2002. Comparatively, there was a decrease in low birth weight babies born to all white mothers, 6.2 in 2001 to 6.1 in 2002. Similarly, the percentage of low birth weight babies to Asian and Pacific Islander mothers decreased from 8.6 in 2001 to 3.8 in 2002.

Table 11: Low Birth Weight Babies by Race of Mother, District of Columbia, 2001-2002

Race	2001	2002	Percent Change
All Races	12.2	11.6	-4.9
Black	15.5	14.6	-5.8
White	6.2	6.1	-1.6

Source: Department of Health, State Center for Health Statistics Administration

Babies born to teenage mothers are also considered to be at relatively higher risk For infant mortality, when they are of low birth weight. In the District of Columbia, The percentage of low birth weight infants born to mothers under 20 years of age increased from 11.0 in 2001 to 12.3 in 2002.

C. Premature Deaths

An important measure of the health of a given population is the number of premature deaths. If 65 years is used as the age for deaths due to natural causes in the District, then 38 percent of all deaths in the District in 2002 could be regarded as premature (deaths occurring before age 65). The leading causes of premature death were cancer, heart disease, HIV/AIDS, and homicide. Furthermore, to quantify the impact of premature deaths, epidemiologists have employed the measure of "years of potential life lost" (YPLL). This measure aggregates the difference between the actual age at death and the age of natural death for all deaths. For the District of Columbia, the YPLL for 2002 was 64,171 years which translates into a YPLL rate of 12,815.4 per 100,000 population.

Promote Healthy Behaviors

1. NUTRITION AND OVERWEIGHT
2. TOBACCO CONTROL

Nutrition *Nutrition and Overweight are leading health indicators.*

Overview

Issues and Trends:

Nutrition is closely linked to the major causes of disease and disability seen in the District of Columbia and the United States and has a profound impact on the health of Americans. Currently, many people suffer from a large nutrient imbalance, with people consuming too much fat and refined sugars and too few fruits, vegetables and whole grains. Despite the intake of excessive calories, many people have deficiencies of iron, calcium, and folic acid and various other vitamins.

Disparities:

Substantial differences are seen in nutritional health indicators among different segments of the population. Obesity has emerged as a critical problem especially among Hispanic children in the **DC Women's, Infants, and Children (WIC) Program**, and such racial and ethnic disparities are consistently seen throughout the nation.

Opportunities:

Targeting nutrition and fitness information to young children may lead to the adoption of lifelong positive nutrition and exercise habits. This information should be effectively integrated with science and other health curricula, and presented in school from preschool through high school.

Revised 2010 Objectives for Nutrition and Overweight in the District

Iron Deficiency among Children and Women of Childbearing Age Enrolled in WIC

1-1: Reduce iron deficiency to 15 percent or less among infants and children up to the age of 5 years, and among women of childbearing age in the Women, Infants, and Children (WIC) population. **Baseline**: 19.1 percent of WIC infants and children under the age of 5 years were iron deficient according to the Centers for Disease Control and Prevention (CDC) 2000 data from the Pediatric Nutrition Surveillance Survey (PedNSS).

Iron deficiency can result in anemia. Anemia rates vary substantially within race/ethnicity groups with white/non-Hispanic as well as Asian/Pacific Islander children below the age of 5 years showing the lowest anemia rate in the District (11.8 percent and 11.7 percent, respectively); and black non-Hispanics showing the highest (20.4 percent). Hispanics fall in the middle of the spectrum with 15.5 percent of the children being anemic. Data for 2003 show an increase in the anemia rate in the District by 2 percent, mostly due to a further increase in the anemia rate within the black non-Hispanic pediatric population to 24.1 percent.

Rationale: According to information in the nutrition section of the federal 2010 plan, iron deficiency ranges from depleted iron stores without functional or health
Impairment to iron deficiency with anemia, which affects the functioning of several organ systems. Iron deficiency anemia (IDA) can have tragic effects across the life cycle. It is likely to cause such adverse pregnancy outcomes as preterm births and/or low birth weight, if IDA is experienced during a certain trimester. IDA in infancy and childhood causes delays in infant and child development. Iron deficiency can be prevented in infants and young children by teaching families about infant and child nutrition, including promoting breastfeeding of infants, with exclusive breastfeeding for 4 to 6 months; or the use of iron-fortified formulas when formulas are used.

Breastfeeding Initiation and Duration among Postpartum WIC Mothers

1-2.1: Increase the breastfeeding initiation rate among WIC Postpartum mothers to 65 percent. Increase the duration rate among WIC postpartum mothers who breastfeed their infants at least 6 months to 50 percent. **Baseline**: 44.7 percent of WIC enrollees initiated breastfeeding in the early postpartum period and 22 percent of WIC breastfeeding mothers continued to breastfeed at 6 months postpartum according to CDC 2000 data from the PedNSS. In 2003, the percentage of breastfeeding mothers climbed to 48.0 percent for initiation and 26.4 percent for breastfeeding 6 months or more.

1-2.2: Increase the breastfeeding duration rate at 1 year after birth to 25 percent. **Baseline:** In 2003, according to CDC data from the PedNSS, 19.5 percent of breastfeeding mothers breastfed for at least one year.

Rationale: According to Dr. David Satcher, the former US Surgeon General who sponsored the Health and Human Services Blueprint for Action on Breastfeeding, “breastfeeding is one of the most important contributors to infant health.” Infants who are breastfed experience a lower incidence of infections, have an enhanced immune system, and are at reduced risk for chronic diseases later in life. Most leading health organizations, such as the American Academy of Pediatrics, the American Dietetics Association, the World Health Organization and others, recommend that breastfeeding continue at least through a baby’s first year of life.

Prevalence of Overweight according to Body-Mass Index (BMI) among WIC Participants

1-3: Reduce to less than 15 percent, the prevalence of overweight individuals among pediatric WIC participants. **Baseline:** 11.3 percent of WIC infants and children under the age of 5 years are overweight (2000 CDC data from PedNSS).

There is a great disparity between minority group members and the white majority with WIC children of Hispanic origin being obese at a rate of 19.6 percent, whereas the prevalence of overweight in black non-Hispanic children is 10 points lower (9 percent). In 2003, the overweight rate slightly increased to 11.8 percent; without any major shifts among children from racial/ethnic minority group members.

Rationale: Obesity has become one of the major nutrition related issues facing our nation, because of its long-term adverse implications for health. In the District, increasing obesity numbers in parts of the population are countered by a relatively high prevalence of underweight in black or African American children below the age of 5 years enrolled in the WIC program in the District of Columbia (7.6 percent compared to 5.4 percent nationwide, according to the 2002 PedNSS data). Left unchecked, the increasing incidence of obesity among children, as well as adults, will negatively impact rates of diabetes, cardiovascular disease, and personal wellness in general.

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan* under Goal 19: Promote health and reduce chronic disease associated with diet and weight, comparable objectives are the following:

!9-1: Healthy weight in adults
19-2: Obesity in adults
19-3: Overweight or obesity in children
19-12: Iron deficiency in young children and in females of childbearing age

Focus Area 1: Nutrition and Overweight - Revised 2010 Objectives, Baselines and Goals

Revised 2010 Objective	Baseline	2010 Goal
1-1. Reduce iron deficiency to 15 percent or less among infants and children up to the age of 5 years, and among women of childbearing age in the Women, Infants, and Children (WIC) population.	19.1 percent of WIC infants and children under the age of 5 years were iron deficient, according to the 2000 Centers for Disease Control and Prevention (CDC) data from the Pediatric Nutrition Surveillance Survey (PedNSS). Iron deficiency can result in anemia. Anemia rates vary substantially within race/ ethnicity groups with white non-Hispanic, as well as Asian/ Pacific Islander children below the age of 5 years showing the	No more than 15 percent of infants, children up to the age of 5 years, and women of childbearing age in the WIC population are deficient in iron.

Revised 2010 Objective	Baseline	2010 Goal
	lowest anemia rate in the District (11.8 percent and 11.7 percent, respectively) and black non-Hispanic showing the highest (20.4 percent). Of Hispanic children 15.5 percent are anemic. Data for 2003 show an increase in the anemia rate in the District by 2 percent, mostly due to a further increase in the anemia rate within the black non-Hispanic population to 24.1percent.	
1-2.1. Increase the breastfeeding initiation rate among WIC postpartum mothers to 65 percent. Increase the duration rate among WIC postpartum mothers who breastfeed their infants until 6 months old to 50 percent.	44.7 percent of WIC participants initiated breast-feeding in the early postpartum period and 22 percent of WIC breast-feeding mothers continued to breast-feed at 6 months postpartum (2000 CDC data from the PedNSS). In 2003, the percentage of breastfeeding mothers climbed to 48.0 percent (initiation) and 26.4 percent (6+ months).	65 percent of postpartum mothers enrolled in WIC will breast-feed their babies in the early postpartum period, and at least 50 percent will breast-feed their babies until they are 6 months old.
1-2.2. Increase the breastfeeding duration rate at 1 year after birth to 25 percent.	In 2003, according to CDC data from the PedNSS, 19.5 percent of breastfeeding mothers breastfed for at least one year.	The breastfeeding duration rate at 1 year has been increased to 25 percent
1-3. Reduce to less than 15 percent, the prevalence of overweight individuals among WIC participants.	11.3 percent of WIC infants and children under the age of 5 years were overweight (2000 CDC data from PedNSS).	Less than 15 percent of WIC participants will be overweight, according to their Body/Mass Index (BMI).

Focus Area 2: Tobacco Use

Tobacco Use is a Leading Health Indicator.

Overview

Issues and Trends:

Tobacco use is one of the most preventable causes of death and disease in the nation. It is a major contributory risk factor for chronic disease conditions such as stroke, heart attack, emphysema, chronic bronchitis, and specific types of cancer, including lung, bladder, mouth/pharynx, esophagus, breast, cervix, kidney, larynx, and pancreas. Smoking is also a factor in low birth weight, further compounding the economic burden on society.

In the District of Columbia, 20.4 percent of adults, 9.4 percent of junior high school and 14.7 percent of high school students were identified as current cigarette smokers. In 2002, of the 5,851 deaths in the District, 726 were attributed to smoking. With the District having one of the highest death rates associated with cancer and cardiovascular diseases, chronic disease contributory factors such as smoking and obesity require aggressive intervention strategies and initiatives or they will continue adversely affecting the health status outcomes of District residents.

Disparities:

Inequalities in income, education, and access to care affect health disparities. This is further evidenced in the District, whereby a majority of the smoking related factors contributing to the higher morbidity and mortality rates are reported in communities with the highest poverty rates, least education, and limited access to care.

In 2002, the greatest percentage of underserved, uninsured residents in low to middle income households were in Wards 6,5, and 7 (Vital Statistics). These communities suffered a greater incidence of chronic diseases and reported having a higher percentage of the population of current smokers (BRFSS). The residents were primarily African Americans, a large percentage of the District's uninsured population, with limited access to care and minimal, if any, daily physical activity.

Opportunities:

The CDC Quitline planning and capacity-building grant awarded in 2004 will provide the Department of Health's **Tobacco Control Program** (TCP) with the opportunity to partner with stakeholders and other affiliates in the development of a District-wide cessation telephone line. This will serve as a step towards furthering community and organizational collaboration and providing a strong foundation for rendering counseling and support to those who want to quit or just need assistance in staying smokefree.

A series of roundtable discussions is scheduled to take place that will include brainstorming and long-term large scale planning to build community support. Key community stakeholders and participating organizations will include representatives from groups that claim to have experienced tobacco related disparities. Participation will also be extended to representatives and members of special populations such as: African American residents, the gay and lesbian advocates, the Latino community, American Asian/Pacific Islanders, seniors and other priority groups.

Revised 2010 Objectives for Tobacco Use in the District

Prevalence of Tobacco Use

2-1.1: Reduce to 14 percent the proportion of adults (18 years or older) who are current smokers. **Baseline:** 20.4 percent of adults in the District were current smokers in 2002 (Behavioral Risk Factor Surveillance System or BRFSS).

2-1.2: Reduce to 20 percent the proportion of adult Hispanics (18 years and older) who are current smokers. **Baseline:** 28.0 percent in 2002 and 24.2 percent in 2003 of Hispanics were current smokers in the District (BRFSS).

2-1.3: Reduce the proportion of young people in grades 9-12 who have ever smoked cigarettes to no more than 50 percent. **Baseline:** 56.7 percent of young people in grades 9-12 had tried cigarettes in 2001 (District of Columbia Youth Risk Behavior Survey or DC YRBS).

2-1.4: Reduce to no more than 16 percent the proportion of young people in grades 9-12 who report that they are current smokers. **Baseline:** 16.9 percent of boys and 12.3 percent of girls were smokers in 2000 (DC YRBS).

2-2: Increase abstinence from tobacco use by pregnant women to 98 percent. **Baseline:** 94.5 percent of pregnant women abstained from smoking in 1997, according to hospital records.

2-3. Increase to 75 percent the proportion of patients who receive advice to quit smoking from a health care provider during the reporting year. **Baseline:** 53.6 percent of the total population had received such advice in 1996 (BRFSS).

Rationale: Tobacco use is the single most preventable cause of death and disease in our society (Surgeon General's Report in 2000). In 1997, the death rate from lung cancer in the District of Columbia was 40.8 per 100,000

population compared to the national average of 37.3 per 100,000 population. Death rates from lung cancer are among the clearest indicators of the burden of tobacco use. Smoking is estimated to cause 4,927 residents to die prematurely according the CDC report on *Investment in Tobacco Control – State Highlights.* Tobacco use among young people remains one of the most critical health priorities according to the Surgeon General's Report of 2000.

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan* under Goal 27: Tobacco use, comparable objectives are the following:

27-1: Adult tobacco use
27-2. Adolescent tobacco use
27-3. Initiation of tobacco use
27-6: Smoking cessation during pregnancy
27-7: Smoking cessation by adolescents

Focus Area 2: Tobacco Use -Revised 2010 Objectives, Baselines and Goals

Objective	Baseline	2010 Goal
2-1.1. Reduce to 14 percent the proportion of adults (18 years or older) who are current smokers.	20.4 percent of adults in the District were current smokers in 2002 (Behavioral Risk Factor Surveillance System or BRFSS).	No more than 14 percent of adults are current smokers.
2-1.2. Reduce to 20 percent the proportion of adult Hispanics (18 years and older) who are current smokers.	28.0 percent in 2002 and 24.2 percent in 2003 of Hispanics were current smokers in the District (BRFSS).	No more than 20 percent of Hispanics in the District are current smokers.
2-1-3. Reduce the proportion of young people in grades 9-12 who have ever smoked cigarettes to no more than 50 percent.	56.7 percent of young people in grades 9-12 had tried cigarettes in 2001 (District of Columbia Youth Risk Behavior Survey or DC YRBS).	No more than 50 percent of young people in grades 9-12 have ever smoked cigarettes.
2-1.4. Reduce to no more than 16 percent the proportion of young people in grades 9-12 who report that they are current smokers.	16.9 percent of boys and 12.3 percent of girls were smokers in 200. (DC YRBS).	No more than 16 percent of young people in grades 9-12 are current smokers.
2-2. Increase abstinence from tobacco use by pregnant women to 98 percent.	94.5 percent of pregnant women abstained from smoking in 1997, according to hospital records.	98 percent of pregnant women abstain from smoking.
2-3. Increase to 75 percent the proportion of patients who receive advice to quit smoking from a health care provider during the reporting year.	53.6 percent of the total population had received such advice in 1996 (BRFSS).	75 percent of patients receive advice to quit smoking from a health care provider during the reporting year.

Promote Healthy and Safe Communities

3. ENVIRONMENTAL HEALTH AND FOOD SAFETY
4. INJURY PREVENTION
5. PEDIATRIC DENTAL HEALTH

Focus Area: Environmental Health and Food Safety

Environmental quality is a leading health indicator.

Overview

Issues and Trends:

With increased global travel and trade come increased concerns over the spread of infectious agents; for example, West Nile virus and avian (bird) flu present serious health concerns. Safeguarding the drinking water supply and the food supply from infectious agents and hazardous chemicals has taken on a new urgency in light of global unrest and terrorism. **The Environmental Health Administration** is addressing these concerns through its **Animal Disease Prevention Division, Rodent Control Program, Food Protection Program, and Water Quality Division**.

Recent studies have shown an association between very low blood lead levels in young children and impaired neurological and behavioral functions. Consistent with the recommendations from the United States Centers for Disease Control and Prevention, the District of Columbia considers ten micrograms and above of lead per deciliter to be the level of concern (an "elevated blood lead level"); and fifteen micrograms and above of lead per deciliter as lead poisoning. The Childhood Lead Poisoning Prevention Program and the Lead-Based Paint Management Program are working, in conjunction with other District agencies, such as the Department of Housing and Community Development and the Department of Consumer and Regulatory Affairs, to ensure that lead hazards are abated and controlled, particularly in housing and child-occupied facilities. Elevated blood lead levels in children typically result from lead-based paint hazards, such as deteriorated, chipping, or peeling lead-based paint; lead-based paint on friction or impact surfaces such as windows, doors, and stairs; lead dust; and lead-contaminated soil; however, ethnic medicinal products, food, food containers, and toys are also of concern. While lead in drinking water contributes to elevated levels of lead in the blood, the Department of Health has concluded that lead in drinking water is not a primary source of elevated blood lead levels.

The District of Columbia does not meet air quality standards for ozone or fine particulate matter, which contribute to smog and unhealthy conditions. For the most part, these pollutants are transported to the District from as far away as the Ohio Valley. Recent federal regulatory efforts aim to reduce this pollution, but may not result in sufficient reductions in time to meet federal deadlines for attaining the air quality standards in the District.

Another trend is the widespread interest in cleaning up abandoned and vacant land parcels that are contaminated with hazardous substances and petroleum products, thereby permitting the redevelopment of scarce urban land resources, facilitating the creation of green space and recreational facilities, and reducing sprawl. There is also

a growing interest in the use of Green Building techniques, which reduce the use of toxic chemicals and promote energy conservation, as well as Integrated Pest Management (IPM), which favors the use of structural modifications and the use of the least toxic products to control unwanted pests and weeds at home, in the workplace, and in parks and playgrounds.

Disparities:

Individuals suffering from chronic diseases and/or with compromised immune systems are especially vulnerable to the adverse effects associated with degraded environmental conditions, as are children, pregnant and nursing women, the elderly, and individuals with chemical sensitivities. Poverty can exacerbate these problems, as many people cannot afford to correct adverse environmental conditions in their homes. The public schools are in need of substantial repairs and renovations without which children may be at risk of exposure to asbestos, lead-based paint, mold, and disease-carrying vermin. There is a need for public education and outreach on simple measures that people can take to maintain healthy homes, workplaces, and play grounds. With its substantial immigrant population, the District needs to be mindful of providing environmental education and services in languages and forms that are accessible to the District's diverse population.

Opportunities:

The District receives substantial federal grants, including grants to safeguard against bioterrorism, to perform lead hazard control, and to protect our air, land, and water resources. The District recently entered into a new partnership agreement with the United States Food and Drug Administration to refine and update the Food Code, and to enhance its implementation. The District also has opportunities to seize upon the public enthusiasm and funding opportunities for Brownfields cleanup and redevelopment. But perhaps the greatest opportunities can be found with the many talented people who reside in the District and who work here, and who carry within them a tremendous base of knowledge and passion for the protection of the public health and the environment.

Revised 2010 Objectives for Environmental Health and Food Safety

Waterborne Disease from Infectious Agents and Chemical Poisoning

3-1: Reduce outbreaks of waterborne diseases from infectious agents and chemical poisonings to no more than 11 per year with a decrease to zero.
Baseline: According to the CDC, there are 900,000 cases of waterborne disease in the US each year, and possibly as many as 900 deaths each year.

Rationale: There is only one community water supply in the District of Columbia – the Potomac River. There were zero waterborne diseases from infectious agents or chemical poisonings reported in 1997. Ongoing upgrades of the water supply system should ensure that the current status will be maintained and the 2010 goal of zero outbreaks achieved.

Blood Lead Levels

3-2. Reduce the prevalence of blood lead levels in excess of10 ug/dL in District children 6 months to 6 years in age and ensure that no District child in this age group has a blood lead level in excess of 10 ug/dL. **Baseline:** In 1997, 86 or three percent (3%) of District children screened had blood lead levels exceeding 15 ug/dL (Source: DC . Bureau of Labs).

Rationale: The District possesses an aging housing stock of which 95 percent of residences were built prior to 1978; the use of lead paint in residences was not banned until 1978. The recommended action is to ensure that property owners provide lead-safe homes in any dwelling where a child under the age of six resides or visits.

Exposure to Air Pollutants

3-3: Improve air quality to healthy levels for 100 percent of the people who reside in and visit the District by attaining and maintaining the National Ambient Air Quality Standards (NAAQS) for the District. **Baseline:** In 2001, air quality in the District did not meet the new national standards for fine particles or the 8-hour ozone standard.

Rationale: The District and the surrounding greater metropolitan area do not meet the NAAQS (neither the one-hour nor eight-hour standards); the greater metropolitan area is classified as a serious ozone nonattainment area.

Clearance of National Priorities Hazardous Waste Sites

3-7. Eliminate significant health risks from the National Priority List (NPL) of hazardous wastes sites, as measured by the level of site cleanup performance sufficient to eliminate the immediate and significant health threats as specified in the sites' health assessments. The Washington Navy Yard is the only site in the District that is on the NPL. **Baseline:** Remediation of the Washington Navy Yard was begun as part of a Corrective Action Order issued by the EPA in 1998.

Rationale: Site remediation is part of a nationwide action. Nationally in March of 1990, 1,079 sites were on the NPL list; of these, health assessments have been conducted for approximately 1,000.

Additionally, there are two programs in the Resource Conservation and Recovery Act (RCRA) that address contaminated sites. One addresses hazardous waste (HW) sites and the other Leaking Underground Storage Tank (LUST) sites. At the end of FY 2004, as part of the RCRA Subtitle I programs, of the 1,490 LUST remediation cases that were opened since the inception of the program, 72 percent were completely remediated. Work is underway for nearly 450 sites.

Sentinel Environmental Diseases

3-8. Work with the National Capital Poison Control Center to identify the total number of accidental pesticidal exposures, routes of exposure, and types of pesticides involved. Design an outreach and education program targeted to reduce the causes of the most frequent types of exposures. **Baseline**: To be determined.

Rationale: This objective is consistent with the five-year strategic plan for the pesticide program currently conducted in partnership with the National Capital Poison Control Center. The program provides baseline data on pesticide poisonings for 1996 and 1997. Future agreements are projected to obtain the data on a three-five year cycle.

Food Safety

Infections Caused by Food Pathogens

3-9: Reduce infections caused by key foodborne pathogens to incidences per 100,000 population of no more than those listed below:

Salmonella species	2
Escherichia coli 0157:H7	0
Listeria monocytes	0
Unknown etiology	3

Rationale: According to the federal *Healthy People 2010 c*hapter on Food Safety, “The general trend toward increased resistance by microorganisms to multiple antimicrobial agents heightens public health concerns about treatment options and health care costs associated with foodborne illnesses. Of particular concern is the potential for transmission of antimicrobial-resistant pathogens to humans through the food supply. For these reasons, increased testing is planned to identify and monitor changes in patterns and trends of antimicrobial resistance in both human and animal populations.”

Infections Caused by Salmonella enteriditis

3-10: Reduce outbreaks of Salmonella enteriditis to fewer than 25 outbreaks

yearly. **Baseline:** Nationally in 1989, there were 77 outbreaks.

Rationale: From the federal *Healthy People 2010* chapter on Food Safety, there is the following regarding foodborne illnesses. The success of improvements in food production, processing, preparation, and storage practices can be measured through the reduction in outbreaks of disease caused by foodborne pathogens. An outbreak occurs when two or more cases of a similar illness result from eating the same food. Smaller outbreaks – those with fewer cases – may be a direct result of improved food preparation practices and better epidemiologic followup once cases are identified.

Implementation of the 1999 Food Code for Institutional Food Operations And the Uniform Food Protection Code

3-11: Adopt and implement the 1999 Food Code for Institutional food operations and the new Uniform Food Protection Code that sets recommended standards for regulation of all District food operations. **Baseline:** As of March 2005, 21 of the 56 states and territories has adopted the 1999 Food Code, representing 32 percent of the United States population. The 1999 Food Code was adopted in the District in 2003 and implementation is in progress.

Rationale: It had been thirty years with no updates in the District's laws relating to the food industry.

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan*, comparable objectives are the following:
8-1: Harmful air pollutants
8-4: Airborne Toxins
8-6: Waterborne disease outbreaks
8-11: Elevated blood lead levels in children.
8-12: Risks posed by hazardous sites.
8-13: Pesticide exposures
10-1: Foodborne infections
10-6. Safe food preparation practices in retail establishments.

Focus Area 3: Environmental Health and Food Safety - Revised 2010 Objectives, Baselines and Goals

	Environmental Health	
Objective	Baseline	2010 Goal
3-1. Reduce outbreaks of waterborne diseases from infectious agents and chemical poisoning to no more than 11 per year with a decrease to zero.	According to the CDC, there are 900,000 cases of waterborne disease in the US each year, and possibly as many as 900 deaths each year.	There are zero outbreaks of waterborne diseases from infectious agents and zero chemical.

Objective	Baseline	2010 Goal
3-2. Reduce the prevalence of blood lead levels in excess of 10 ug/dL in children 6 months to 6 years in age, and ensure that no District child in this age group has a blood lead level in excess of 10ug/dL.	In 1997, 86 or 3 percent of District children screened had blood lead levels exceeding 15 ug/dL (Source: Bureau of Labs.).	The prevalence of blood lead levels in excess of 10 mg/dL in children ages 6 months to 6 years has been reduced and no District child in this age group has a blood lead level exceeding 10 ug/dL.
3-3. Improve air quality to healthy levels for 100 percent of the people who reside in and visit the District.	In 2001, air quality in the District did no meet the new national standards for fine particles or the 8-hour ozone standard.	Air quality has been improved to healthy levels for 100 percent of the people who reside in and visit the District.
3-4. Dropped. 3-5. Dropped. 3-6. Dropped.		
3-7. Eliminate significant health risks from the National Priority List (NPL) of hazardous wastes sites, as measured by the level of site cleanup performance sufficient to eliminate the immediate and significant health threats as specified in the sites' health assessments. The Washington Navy Yard is the only site in the District that is on the NPL.	Remediation of the Washington Navy Yard was begun as part of a Corrective Action Order issued by the EPA in 1998.	Remediation of the Washington Navy Yard, the only hazardous waste site on the NPL that is in the District, is well underway to being accomplished.
3-8. Work with the National Capital Poison Control Center to identify the total number of accidental pesticidal exposures, routes of exposure, and types of pesticides involved. Design an outreach and education program targeted to reduce the causes of the most frequent types of exposures.	Baseline: to be determined.	An outreach and education program target has been designed and implemented that has led to the reduction of causes of exposures to pesticides in the District.

	Food Safety	
3-9. Reduce infections caused by key foodborne pathogens to incidences per 100,000 of no more than those listed below: Salmonella species 2 Escherichia coli 0157:H7 0 Listeria monocytes 0 Unknown etiology. 3 (Figures are per 100,000 people.)	In 1998 in the District: Salmonella species 2 Escherichia coli 0157:H7 0 Listeria monocytes 0 Unknown etiology. 3 3 (Figures are per 100,000 people.) (EHA Database).	In 2010 in the District: Salmonella species 0 Escherichia coli 0157:H7 0 Listeria monocytes 0 Unknown etiology. 1 (Figures are per 100,000 people.)
3-10. Reduce outbreaks of Salmonella enteriditis to fewer than 25 outbreaks yearly.	Nationally in 1989, there were 77 outbreaks. In 1988 in the District, there were two outbreaks.	There have been zero outbreaks of Salmonella enteriditis in this year.
3-11. Adopt and implement the 1999 Food Code for institutional food operations and the new Uniform Food Protection Code that sets recommended standards for regulation of all District food operations.	Twenty-one (2) states and territories had implemented the 1999 Food Code for institutional food operations by March 2005. The 1999 Food Code was adopted in the District in 2003 and implementation is in progress.	There has been full adaptation and implementation of the 1999 Food Code for institutional food operations and the new Uniform Food Protection Code for regulation of all District food operations.

Focus Area: Injury/ Violence Prevention *Injury and Violence are leading health indicators.*

Overview

Issues and Trends:

It is vital that public and private agencies in the District continue to collaborate in addressing injury and violence prevention. The District of Columbia Department of Health, **Division of Injury and Violence Epidemiology (DIVE)** has been working diligently for the last three (3) years in collaboration with public and private agencies and community-based organizations to reduce violence and injury in the District. Public, private, and community-based agencies throughout the District have traditionally approached violence and injury outreach from a judicial, educational, and/or environmental perspective. The focus of the Department of Health (DOH) is to take a holistic approach and include health as a focus area on violence and injury prevention.

In 2004, the index crime total, as reported to FBI's Uniform Crime Reporting Program by the District of Columbia Metropolitan Police Department, has decreased by 36 percent (36%), from 52,136 in 1997 to 33,252. Homicide crimes have decreased by 34 percent (34 %) from 301 in 1997 to 198 in 2004. However, there was no change in forcible rape cases (218) from 1997 to 273 in 2004. Homicide continues to be the leading cause of death for District of Columbia residents age 10-34 and unintentional injuries for 5 - 9 year olds in 2001. Suicide is the third leading cause of death for 15 - 24 year olds.

The National Safety Council estimates the average economic cost of public injuries is $880,000 per death and $9,400 per disabling injury in 2003.

Disparities:

From 2000 – 2002, for individuals ages 1-34, race-specific data indicate that the black non-Hispanic population suffered 421 homicides, 26 suicides, and 99 unintentional injury-related deaths. In contrast, the white non-Hispanic population suffered only 15 homicides, 7 suicides, and 17 unintentional injury-related deaths.

Opportunities:

Preventing violence before it occurs was addressed during DIDE's three citywide youth violence prevention summits titled *"My World, My Views, My Solutions".* The target audience was District of Columbia (DC) youth, ages 12-21, who were at risk for violence and antisocial behaviors. The recruited youth participated in leadership, communication building and advocacy training. The youth assisted in planning the antiviolence summits, and the development of recommendations on violence prevention in their homes, schools and communities. Three (3) summits

were convened this year (2004) and at the 3rd summit the recommendations developed by the youth were presented and discussed with Mayor Anthony Williams. DOH/DIDE is in the process of planning a PREVENTION webcast on youth violence prevention that would be developed, designed and implemented by the youth.

In addition, an injury and violence surveillance system is being developed to provide ongoing trends of injury and violent crimes and their risk factors in the District, which would aid in the implementation of strategic interventions. Mechanisms are being put in place for the passage of an Injury Reporting Bill, which would require all trauma centers, emergency departments, ambulatory clinics, and subordinate agencies, i.e., DC Metropolitan Police Department, DC Fire Department and Emergency Medical Services, and the Office of the Chief Medical Examiner to report all injuries to the Department of Health.

Revised 2010 Objectives for Injury/ Violence Prevention

Firearm-related Deaths

4-1: Reduce firearm-related deaths in the District to no more than 25 per 100,000 population. **Baseline:** The age-adjusted rate of deaths due to firearms has decreased from 37.28 per 100,000 population in 1997 to 31.32 per 100,000 population in 2002. (Source: WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics Systems for number of deaths. Bureau of Census for population estimates.)

Homicides

4-2: Reduce homicides in the District to no more than 15 per 100,000 population. **Baseline**: The homicide rate in the District has decreased from 45.2 per 100,000 population in 1997 to 34.6 per 100,000 population in 2004. (Rate calculated from DC population of 572,059. Source: DC Police Department)

Suicides

4-3. Reduce the suicide rate in the District to no more than 3.0 per 100,000 population. **Baseline:** The suicide rate in the District has decreased from an age-adjusted death rate of 6.20 per 100,000 population in 1997 to 5.13 per 100,000 population in 2002. (Source: WISQARS, National Center for Injury Prevention and Control, CDC, NCHS, National Vital Statistics Systems for number of deaths. Bureau of Census for population estimates.)

Rape and Attempted Rape

4-4: Reduce rape and attempted rape of females 12 years of age and older to no more than 25 per 100,000 population. **Baseline:** In 2004, 218 cases of forcible rape, a crude rate of 38.1 per 100,000 population was reported by the DC Metropolitan Police. (Rate calculated from DC population of 572,059, DC Police Department)

Maltreatment of Children

4-5. Reduce to less than 5.5 per 1,000 population the age-adjusted rate for maltreatment of children in the District. **Baseline:** In 1997, there was a crude rate for maltreatment of children of 49.8 per 1,000 children. In 2001, the crude rate dropped to 39.6 per 1,000 children and in 2002, the crude rate increased to 45.0- per 1,000 children. (Source: Child Welfare League of America, 2001).

Establishment of Trauma/Injury Registry at DOH

4-6.1: Establish an trauma/injury registry at the DOH to which data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics are reported on a regular basis. **Baseline:** As of 2005, no injury registry has been established at the DOH. The Division has been working collaboratively with the DOH Emergency Medical Services Administration to identify funds to establish such a registry.

Increase Data Reporting to DOH Injury Registry

4-6.2: Increase to 90% the proportion of emergency rooms, trauma centers, and ambulatory clinics reporting data to the DOH trauma/injury registry. **Baseline**: To be established after funding of the Trauma/Injury Registry has been secured.

Rationale: Nationally, violence and abusive behavior continue to be major causes of death, injury and stress. In the District, baseline data for many of the indicators and progress measures indicate that violence and abuse behavior constitute even more of a problem for this city than indicated by the national data. Injuries continue to be the second leading cause of death for young persons ages 15 to 24 and the leading cause of death for African Americans in this age group. Understanding the incidence and prevalence of violence-related injuries in the District of Columbia creates opportunities for the development and implementation of comprehensive and effective prevention measures. The establishment of a Trauma/Injury Registry at DOH will permit regular reporting to the public on the incidence and types of injuries suffered by residents, the development of epidemiological studies of the nature and origin of the various types of trauma injuries, and a resource of information on trauma injuries upon with strategic planning of emergency response mechanisms can be based.

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan* under Goal 15: comparable objectives are the following:
15-3: Firearm related deaths
15-32: Homicides
15-33: Maltreatment and maltreatment fatalities
15-35: Rape or attempted rape

Focus Area 4: Injury/Violence Prevention - Revised Objectives, Baselines and 2010 Goals

Objective	Baseline	2010 Goal
4-1. Reduce firearms related deaths in the District to no more than 25 per 100,000 residents.	The age-adjusted rate of deaths due to firearms has decreased from 37.28 per 100,000 people in 1997 to 31.32 per 100,000 people in 2002 (Source: National Center for Injury Prevention and Control, CDC, National Center for Health Statistics (NCHS), National Vital Statistics Systems for number of deaths, Bureau of Census for population estimates..	No more than 25 firearms related deaths per 100,000 people occur in the District in this year.
4-2. Reduce homicides in the District to no more than 15 per 100,000 residents.	The homicide rate in the District has decreased from 45.2 per 100,000 people in 1997 to 34.6 per 100,000 people in 2004 (Rate calculated from DC population of 572,059. Source DC Police Department).	No more than 15 homicides per 100,000 residents occur in the District in this year.
4-3. Reduce the suicide rate in the District to no more than 3.0 per 100,000.	The suicide rate in the District has decreased from an age-adjusted rate of 6.20 per 100,000 people in 1997 to 5.13 per 100,000 people in 2002. (Source: WISQARS, National Center for Injury Prevention and Control, CDC, NCHS, National Vital Statistics System for numbers of deaths. Bureau of Census for population estimates)	The suicide rate is no more than 3.0 per 100,000 residents in this year.
4-4. Reduce rape and attempted rape of females 12 years of age and older to no more than 25 per 100,000 residents.	In 2004, 218 cases of forcible rape, a crude rate of 38.1 per 100,000 people, were reported by the DC Metropolitan Police (Rate calculated from DC population of 572,059, DC Police Department).	The age-adjusted rate for rape and attempted rape in the District does not exceed 25 per 100,000 residents in this year.
4-5. Reduce to less than 5.5 per 1,000 the age-adjusted rate for maltreatment of children in the District.	In 1997, there was a crude rate of 49.8 maltreated children per 1,000 children; in 2001, the crude rate dropped to 39.6 per 1,000 children; and in 2002 the crude rate increased to 45.0 per 1,000 children (Source: Child Welfare League of America, 2001).	The age-adjusted rate for maltreatment of children in the District does not exceed 5.5 per 1,000 people in this year.

Objective	Baseline	2010 Goal
4-6.1. Establish an trauma/injury registry at the DOH to which data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics are reported on a regular basis.	No trauma/injury registry has been yet established at the DOH as of 2005. An application was sent to CDC in February of 2005 for funds to establish such a registry.	A trauma/ injury registry has been established at the DOH to which data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics are reported on a regular basis.
4-6.2. Increase to 90 percent the proportion of emergency rooms, trauma centers, and ambulatory clinics reporting data to the DOH trauma/ injury registry.	Baseline to be determined. All level one trauma centers (of which there are four) have registries that collect data on the external causes of injury, but are not mandated to report this information to the DOH. The number of treatment sites voluntarily reporting data to the DOH on intentional and unintentional injuries seen on-site can be considered as a baseline to which more sites can be added after reporting becomes mandatory.	90 percent of emergency rooms, trauma centers, and ambulatory clinics regularly report data to the DOH trauma/injury registry.

Focus Area: Pediatric Dental Health

Overview

Until the hiring of an oral health manager in the fall of 2002 and the subsequent establishment of **the Oral Health Program - now called the Oral Health Division** -, the District of Columbia (DC) had been without dental directive since 1989. The establishment of the Oral Health Division has attempted to address some of the many oral health issues that DC faces by accomplishing the following:

- Developing and implementing a School-based Dental Sealant Project;
- Developing of Child Health Certificate (CHC) and Oral Health Assessment (OHA) forms;
- Convening the District of Columbia Oral Health Coalition; and
- Administering the "Provision of Oral Health Services to Children with Special Health Care Needs" project.

Issues and Trends:

Unfortunately, it is still apparent that the District's children, many of whom are underinsured or uninsured, are lacking in the routine dental care that is afforded most of the nation's children. Not only is dental pain the number one complaint of children in the offices of school nurses, but dental caries is the number one preventable disease in children.

Disparities:

The Centers for Disease Control and Prevention (CDC) estimate that 20 percent of the nation's children have 80 percent of the tooth decay. Obviously, residents, particularly children, are experiencing a gap in dental services; this is a critical need to fill.

Opportunities:

A critical priority of the Oral Health Division is to gather baseline data on the dental needs of the District's most vulnerable children, and use this information to develop an easily replicable model program for enhancing access to dental caries prevention, education and treatment for the District's underinsured and uninsured children. This model program could be replicated throughout the city's wards, with special attention to those – in Wards 1,2,5,6,7, and 8 – who have the greatest need for services. The Oral Health Division has taken steps to gather and document some baseline data by 1) conducting a limited oral health needs assessment in 2002 which was funded by the Robert Wood Johnson's Community Voices Collaborative and 2) collecting data through its School-based Dental Sealant Project, as well as oral health screenings that it performs through the District.

Revised 2010 Objectives for Pediatric Dental Health

Dental Caries in Children and Adolescents

5-1: Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition), so that the proportion of children with one or more cavities (filled or unfilled) is no more than 15 percent among those 2-4 years of age; 40 percent among children 6-8 years of age; and 55 percent among adolescents 15 years in age. **Baseline**: Nationally between 1988 and 1994, 18 percent of children ages 2-4 years; 52 percent of children ages 6-8 years; and 61 percent of adolescents 15 year of age had one or more decayed teeth. (Local baseline to be determined)

Decayed Teeth and Children and Adolescents

5-2: Reduce untreated cavities in primary and permanent teeth (mixed dentition), so that the proportion of children with unfilled, decayed teeth is no more than 12 percent among those 2-4 years of age; 22 percent in children 6-8 years of age; and 15 percent among adolescents 15-year of age. **Baseline**: Nationally, between 1988 and 1994, 16 percent of children ages 2-4 years; 29 percent of children ages 6-8 years; and 20 percent of adolescents 15 years of age had one or more decayed teeth. (Local baseline to be determined.)

Children with Protective Sealants in Permanent Molar Teeth

5-3: Increase to at least 70 percent the proportion of children 8 and 14 years of age who have received protective sealants in permanent molar teeth. **Baseline:** Nationally, between 1988 and 1994, 23 percent of children 8 years of age, and 24 percent of adolescents 14 years of age received sealants on permanent molar teeth. (Local baseline to be determined.)

Caries Screening for Children 1-5 Years of Age

5-4: Increase to at least 18 percent, the proportion of children 1-5 years of age who receive caries screening by a qualified health care professional to determine the existence of any observable decay and for counseling on the need to increase the source of fluoride or decrease potential excessive sources of fluoride. **Baseline:** Nationally, between 1955 and 1998, 18 percent of eligible 1-5 year old children had received dental assessments. (Local data to be determined.)

Oral Screening for Children Entering School Programs for the First Time

5-5.1: Increase to at least 85 percent the proportion of children entering school programs for the first time who have received an oral health screening. **Baseline:** To be determined.

Screening Children Receiving Referrals for Follow-up Services

5-5.2: Increase to at least 25 percent, the proportion of children who have been screened and need referral for diagnostic, preventive, and treatment services. **Baseline**: To be determined.

Treatment of Screened Children within 90 Days of Referral

5-5.3: Increase to at least 30 percent, the proportion of children referred for treatment who begin their treatment within 90 days. **Baseline:** To be determined.

School-based Health Centers with an Oral Health Component

5-6: Increase to 25 percent the proportion of school-based health centers (prekindergarten through 12th grade) with an oral health component. **Baseline:** This objective has already been achieved and is included as a status indicator.

Community-based Health Centers with a Direct Oral Health Education and Service Component

5-7: Increase to 5 percent the proportion of local community-based health centers that have a direct oral health education and service component. **Baseline:** This objective has already been achieved and is included as a status indicator.

Viable System for Recording and Referring Infants and Children with Craniofacial Anomalies to Craniofacial Anomaly Teams

5-8: Develop and implement a viable system for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly teams within the District of Columbia. **Baseline**: Nationally in 1993, 23 states had systems for recording and referring infants and children with craniofacial anomalies to craniofacial anomaly teams. Local data to be determined

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan,* comparable objectives are as follows:
21-1: Dental caries experience
21-2: Untreated dental decay
21-8: Dental sealants
21-12: Dental services to low-income children
21-13: School-based health centers with oral health component
21-15: Referral for cleft lip or palate

Focus Area 5: Pediatric Dental Health – Revised 2010 Objectives, Baselines, and Goals

Objective	Baseline	2010 Goal
5-1. Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition) so that the proportion of children with one or more cavities (filled or unfilled) is no more than 15 percent among those 2–4 years of age, 40 percent among children 6–8 years of age, and 55 percent among adolescents 15 years in age.	Nationally, between 1988 and 1994, 18 percent of children ages 2–4 years. 52 percent of those ages 6–8 years, and 61 percent of adolescents 15 years of age had experienced dental caries. (Local baseline to be established)	No more than 15 percent of children 2–4 years in age, 40 percent of children 6–8 years in age, and 55 percent of adolescents age 15 years of age will have one or more cavities (filled or unfilled).
5-2. Reduce untreated cavities in primary and permanent teeth (mixed dentition) so that the percentage of children with unfilled, decayed teeth is no more than 12 percent among children 2–4 years of age. 22 percent among children 6–8 years of age and 15 percent among adolescents 15 years in age.	Nationally, between 1988 and 1 16 percent of children ages 2– years, 29 percent of children ag 8 years, and 20 percent of adolescents 15 years in age ha or more decayed teeth. (Local baseline to be determine	No more than 12 percent of children ages 2–4 years, 22 percent of children ages 6–8 years, and 15 percent of adolescents ages 15 years will have unfilled, decayed teeth.
5-3. Increase to at least 70 percent the percentage of children ages 8 and 14 years who have received protective sealants in permanent molar teeth.	Nationally, between 1988 and 1 23 percent of 8- year- olds and percent of 14- year- olds receiv sealants on permanent molar te	At least 70 percent of children ages 8 and 14 years will receive protective sealants on permanent molar teeth.
5-4. Increase to at least 40 percent, the proportion of 1 – 5 year olds who receive caries screening by a qualified health care professional to determine the existence of any observable decay and for	Nationally, between 1995 and 1 18 percent of eligible 1 – 5 yea age received dental assessmer	At least 40 percent of children ages 1 – 5 years will receive caries screening by a qualified health care professional to determine the existence of any

Objective	Baseline	2010 Goal
counseling on the need to increase the source of fluoride or decrease potentially excessive sources of fluoride.		observable decay and for counseling on the need to increase the source of fluoride or decrease potentially excessive sources of fluoride.
5-5.1. Increase to at least 85 percent the percentage of all children entering school programs for the first time, who have received an oral health screening.	Baseline is to be determined.	At least 85 percent of all children entering school programs for the first time will receive an oral health screening.
5-5.2. Of those children who have been screened and need referral, increase to at least 25 percent the proportion of children receiving a referral for necessary diagnostic, preventive, and treatment services.	Baseline is to be determined.	At least 25% of those children who received screening and needed referral, will receive a referral.
5-6. Increase to 25 percent the proportion of school-based health centers (pre-kindergarten through 12th grade) with an oral health component.	Since 2004, at least 25 percent of school-based health centers have an oral health component. This objective is included as a status indicator.	At least 25 percent of school-based health centers maintain an oral health component.
5-7. Increase to 5 percent, the proportion of local community-based health centers that have a direct oral health education and service component.	As of 2000, 5 percent of local community-based health centers have a direct oral health education and service component. This objective is included as a status indicator.	5 percent of local community-based health centers maintain a direct oral health education and service component.

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Improve Access to Quality Health Care

6. PRIMARY CARE
7. EMERGENCY MEDICAL SERVICES
8. HEALTH CARE FINANCE
9. MATERNAL, INFANT AND CHILD HEALTH AND FAMILY PLANNING
10. PUBLIC HEALTH INFRASTRUCTURE

Focus Area: Primary Care *Primary care and access to care are leading health indicators.*

Overview

Issues and Trends:

The issue of high emergency room utilization remains a problem for the District and its **Primary Care Program in the Department of Health**. Health outreach workers are being trained as health navigators to educate residents on routine, non-acute, urgent and acute care problems.

Disparities:

Access to care continues to burden the District; approximately 52 percent of residents live in primary care Health Professional Shortage Areas. These federally designated areas have a high percentage of minority residents.

Opportunities:

Medical Homes DC has been funded by the Department of Health and other key partners to ensure that every District resident has a medical home regardless of their ability to pay.

Revised 2010 Objectives for Primary Care

Increasing Access by Increasing the Number of National Health Service Corps. Loan Repayment Providers

6-1: Increase access to care by increasing the number of National Health Service Corps Loan Repayment providers in the District of Columbia from 26 to 36. **Baseline:** There were 26 health care providers in the District in 1999. Providers are defined as allopathic physicians, dentists, nurse practitioners, physician assistants, and nurse midwives. (Source: Primary Care Program records)

Rationale: The National Health Service Corps (NHSC) increases access to health care and improves the quality of health care for the District of Columbia's underserved and indigent populations. The NHSC contributes to the District's efforts to attain the goal of zero percent disparity and 100 percent access.

Increase Access by Increasing the Number of Primary Care Treatment Sites in Underserved Areas

6-2: Increase access to care for vulnerable populations in underserved areas by increasing the number of primary care treatment sites from 50 to 60. **Baseline:** There were 50 treatment sites in the District in 1999.

Increase Access by Increasing the Number of HPSA Facility Designations

6-3: Increase access to care for vulnerable populations by increasing the number of Health Professional Shortage Areas (HPSA) Facility Designations from 2 to 5. **Baseline:** There were 2 HPSA Facility Designations in 1999.

Rationale: HPSA designation status is necessary for National Health Service Corps. Provider placement, J-1 Visa waiver physician placement and some grant funding resources.

Evaluation of Impact of New Health Insurance Programs

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6-4. Evaluate the impact (on participating children and their families) of the new health insurance programs implemented in October 1998 – Medicaid Managed Care expansion and the Children's Health Insurance Programs (CHIP)/DC Healthy Families Program. **Baseline:** 10,500 children and their families have been enrolled in the DC Healthy Families Program since its implementation in October 1998.

6-5: Dropped
6-6: Dropped

Retention of National Health Service Corps. and Conrad-30 Program Providers in Underserved Areas after Their Commitment Period

6-7: Retain 40 percent of National Health Service Corps. and Conrad-30 program providers in Health Professional Shortage Areas and Medically Underserved Areas after their commitment period. **Baseline:** FY 04 Target 33 percent; actual 81 percent.

Rationale: The National Health Service Corps (NHSC) increases access to health care and improves the quality of health care for the District of Columbia's underserved and indigent populations. The NHSC contributes to the District's effort to attain the goal of zero percent disparity and 100 percent access.

Evaluation of Patients' Satisfaction with Primary Care Services Provided by Health Insurance Programs

6-7: Evaluate patients' satisfaction with the primary care services provided through the local and federal public health insurance programs in annual assessments with distribution of findings to primary care providers and the general public. **Baseline**: to be added when available.

Comparable National 2010 Objectives:

In the federal *Healthy People 2010 Plan,* comparable objectives are the following:
1-4: Source of ongoing care.
1-5: Usual primary care provider.
1-6: Difficulties or delays in obtaining health care

Focus Area 6: Primary Care - Revised 2010 Objectives, Baselines and Goals

Objective	Baseline	2010 Goal
6-1. Increase access to care by increasing the number of National health Service Corps Loan Repayment providers in the District of Columbia from 26 to 36.	There were 26 health care providers in the District in 1999. Providers are defined as allopathic physicians, dentists, nurse practitioners, physician assistants, nurse midwives.	Access has been increased by increasing to 36 the number of National Health Service Loan Repayment providers in the District.
6-2. Increase access to care for vulnerable populations in underserved areas by increasing the number of primary care treatment sites from 50 to 60.	There were 50 treatment sites in the District in 1999.	Access to care is increased for vulnerable populations in underserved areas by increasing the number of primary care treatment sites to 60.
6-3. Increase access to care for vulnerable populations by increasing the number of Health Professional Shortage Areas (HPSA) Facility Designations from 2 to 5.	There were 2 HPSA Facility Designations in 1999.	Access to care for vulnerable populations is increased by increasing the number of HPSA Facility Designations to 5.
6-4.Evaluate the impact (on participating children and their families) of the new health insurance programs implemented in October 1998 – Medicaid Managed Care expansion and Children's Health Insurance Programs (CHIP)/DC Healthy Families Program.	10,500 children and their families have been enrolled in the DC Healthy Families Program since its implementation in October 1998.	The impact of the new health insurance programs implemented in October 1998 (on participating children and their families) has been evaluated.
6-5. Dropped nd 6.6. Dropped		
6-7. Retain 40 percent of National Health Service Corps. and Conrad-30 program providers in Health Professional Shortage Areas HPSA) and Medically nderserved Areas after their mmitment period.	FY 04 Target 33 percent; actual 81 percent.	40 percent of National Health Service Corps. and Conrad-30 program providers in HPSAs and Medically Underserved Areas are retained after commitment period.

Objective	Baseline	2010 Goal
6-8. Evaluate patients' satisfaction with the primary care services provided through the local and federal public health insurance programs in annual assessments with distribution of findings to primary care providers and general public.	Currently there are no data for collective, quantitative benchmarks. Data to be added when available.	Annual assessments of patients' satisfaction with the primary care services provided through local and federal health insurance programs are conducted with distribution of information to primary care providers and general public.

Focus Area: Emergency Medical Services

Overview

Issues and Trends:

Emergency Preparedness - to ensure that Emergency Medical Technicians are well prepared to protect themselves and their communities in the event of a mass casualty/weapons of mass destruction event, the DC Department of Health (DOH) has stockpiled prophylactic medication to quickly distribute to DC government first responders to ensure continuity of DC government.

Disparities: This situation is as yet unclear.

Opportunities:

Through a HRSA grant for hospital preparedness – **Emergency Medical Services** (EMS) component - , DC DOH was able to purchase equipment and supplies for the DC Fire Department, such as advanced life support drugs, IT equipment for data collection for quality assurance purposes. For private ambulance companies, DC DOH is conducting basic awareness/emergency response training geared toward weapons of mass destruction and also purchased personal protective equipment for the ambulance crews.

Within the DC Fire and EMS Department, the scope of practice for the Emergency Medical Technicians/Basic has increased, allowing them to perform some advanced life support techniques. This trend could send the District into an all ALS (Advanced Life Support) system.

Revised 2010 Objectives for Emergency Health Services

Development of a Clear Standard Specifying the Qualifications, Credentials, and Duties Required to Render EMS in the District of Columbia

7-1.1**:** Develop a document that described in detail the qualifications, credentials, and duties of all emergency medical service (EMS) personnel, including medical directors, emergency medical technicians; paramedics (EMP/P), emergency medical technicians/intermediates (EMP/IP), emergency medical technicians/basic (EMP.B), first responders, and medical dispatchers and call takers. **Baseline:** Action on this objective has been ongoing, since October of 2004. Ambulance regulations are being revised.

Assured Presence in All Emergency 911 Units of Personnel with Advanced Life Support Capability

7-1.2: Ensure that all emergency 911 transport units have personnel with advanced

life support capability as defined by the DOH. **Baseline:** As of 1999, 35 percent of transport units include advanced life support capability.

Response Times in Conformity with National Standards for Critical and Noncritical Patients

7-1.3**:** Ensure that response times (from the time the call was received by dispatch to the time EMS arrives at the scene) will meet the 90th percentile of 8 minutes for critical patients and 16 minutes for noncritical patients, based on the Medical Priority Dispatch System (MPDS). **Baseline:** As of 1999, response times for 911 calls for critical patients in the 90th percentile equal 10.21 minutes based on the MPDS.

Revised and Updated Fire and EMS Pre-hospital Medical Protocols

7-1.4**:** Revise and update current District Fire and EMS Pre-hospital Medical Protocols to meet and reflect training guidelines established by the US Department of Transportation's EMS curricula. **Baseline:** Activities began after 2000.

Assurance of Appropriate Medical Direction of the District's Pre-hospital Personnel

7-1.5: Ensure proper medical direction of pre-hospital personnel in the District. **Baseline**: This objective has been met, because every ambulance company has its own medical director who ensures compliance with the state prehospital protocols.

Development of a Comprehensive Dataset

7-2.1: In conjunction with the EMS Advisory Committee and the private and public ambulance companies certified in the District, develop a comprehensive EMS dataset conforming to the national uniform dataset and linking to other DOH offices. **Baseline:** EHMSA is working in collaboration with the US Department of Transportation and the NEMSIS Group to develop a national EMS comprehensive dataset with a 2003 baseline.

Development of Legislation Mandating Reporting of All Licensed Ambulance Services

7-2.2: Develop legislation requiring all licensed ambulance services to report the established comprehensive dataset to the Emergency Health and Medical Services Administration (EHMSA) in the DOH by January 1, 2002. **Baseline:** This objective is awaiting the development of a standard dataset.

Establishment of a Trauma Registry for the District

7-2.3: In collaboration with the DOH Injury Program, establish a District of Columbia Trauma/Injury Registry that captures all relevant data on utilization, levels of uncompensated trauma care, and indicators of the quality of trauma care. **Baseline**: As of July 2001, there was no Trauma Registry at DOH to which data were reported on a regular basis. An application by the Division of Injury and Violence Epidemiology (DIVE) for funding of the Trauma Registry was submitted to the CDC in February of 2005.

Rationale: The establishment of an Injury/Trauma Registry at DOH will permit the following:

- Regular reporting to the public on the incidence and types of injury trauma suffered by residents;
- Development of epidemiological studies regarding the nature and origin of the various types of trauma injuries; and
- Provision of information on trauma injuries upon which the strategic planning of emergency response mechanisms can be based.

7-3.1: This objective has been dropped.
7-3.2: This objective has been dropped.

Promotion of Wellness and Injury Prevention in the Community

7-4.1: Promote wellness, health, and injury prevention within the community through public education programs and other initiatives. **Baseline:** This reflects ongoing activity. EHMSA is promoting injury prevention through collaboration with DOH/DIVE.

Expansion of Role in Public Health

7-4.2: Define and expand the role of EHMSA in Public Health. **Baseline:** Since 2002, the role of EHMSA has been to expanded to include emergency preparedness.

7-4.3: Support and promote EMS research on Public Health issues. **Baseline:** Since 2003, EMHSA has been applying statistical analysis to examine the quality of prehospital medical care.

Updating of Existing Legislation on Ambulance Services

7-5: Revise and update existing legislation regarding public and private ambulance services relating to its delivery of effective EMS and transport between facilities. **Baseline:** Developmental.

Establishment of an Enforcement Division at EMHSA

7-6: Establish in the DOH EHMSA an Enforcement Division legislatively to ensure compliance with the DOH specified EMS rules and regulations. B**aseline:** This activity began after 2000 and was in place and staffed by 2003.

Rationale: Inspite of the lack of funding, a training in Do Not Resuscitate (DNR) practices was conducted for EMS providers under EHMSA with the support of the Partnership for End of Life Care.

Participation in the Development and Update of the District's Emergency Operations Plan

7-7: Continue participation in the development and update of the District's Emergency Operations Plan for response to current and new threats to the District and surrounding jurisdictions.

Comparable National 2010 Objectives

In Chapter 1 of the federal *Healthy People 2010 Plan*, – Access to Quality Health Services, comparable objectives are the following:
1-10: Delay or difficulty in getting medical care.
1-11: Rapid prehospital emergency medical services.
1-13: Trauma care systems

Focus Area 7: Emergency Medical Services - Revised 2010 Objectives, Baselines, and Goals

Objective	Baseline	2010 Goal
7-1.1 Develop a document that describes in detail the qualifications, credentials, and duties of all emergency medical service (EMS) personnel, including medical directors, emergency medical technicians/ paramedics (EMP/P), emergency medical technicians/ intermediates (EMP/IP), emergency medical technicians/basic (EMP/B), first responders, and medical dispatchers and call takers.	Action on this objective has been ongoing, since October of 2004. Ambulance regulations are being revised.	Documents developed and in use that describe in detail the qualifications, credentials, and duties of all EMS personnel.
7-1.2.Ensure that all emergency 911 transport units have personnel with advanced life support capability as defined by the Department of Health (DOH).	As of 1999, 35 percent of transport units include advanced life support capability.	All emergency 911 transport units have personnel with advanced life support capability as defined by the DOH. *As of 2004, this objective has almost been attained.*

Objectives	Baseline	2010 Goal
7-1.3. Ensure that response times (from the time the call was received by dispatch to the time EMS arrives at the scene) will meet the 90th percentile of 8 minutes for critical patients and 16 minutes for noncritical patients, based on the Medical Priority Dispatch System (MPDS).	As of 1999, response times for 911 calls for critical patients in the 90th percentile equal 10.21 minutes based on the MPDS.	Response times meet the 90th percentile of 8 minutes for critical patients and 16 minutes for noncritical patients.
7-1.4. Revise and update current District Fire and EMS Pre-hospital Medical Protocols to meet and reflect training guidelines established by the US Department of Transportation's EMS curricula.	*Activities began after 2000.*	Current District Fire and EMS pre-hospital Medical protocols meeting and reflect training guidelines. *This goal was accomplished in 2003. Not only were protocols developed, but DCFEMS personnel have received training on the new and current protocols.*
7-1.5. Ensure proper medical direction of pre-hospital personnel in the District.	This objective has been met, because every ambulance company has its own medical director who ensures compliance with the state prehospital protocols.	Proper medical direction of pre-hospital personnel is ensured.
7-2.1. In conjunction with the EMS Advisory Committee and the private and public ambulance companies certified in the District, develop a comprehensive EMS dataset conforming to the national uniform dataset and linking to other DOH offices.	EHMSA is working in collaboration with the US Department of Transportation and the NEMSIS Group to develop a national EMS comprehensive dataset with a 2003 baseline.	Comprehensive dataset is in use in the District.
7-2.2. Develop legislation requiring all licensed ambulance services to report the established comprehensive dataset to the Emergency Health and Medical Services Administration (EHMSA) in the DOH by January 1, 2002.	This objective is awaiting the development of a standard dataset.	Legislation is in effect requiring all licensed ambulance services to report the established comprehensive dataset to EHMSA.
7-2.3. In collaboration with the DOH Injury/ Violence Epidemiology Program, establish a Direct of Columbia Injury/Trauma Registry that captures all relevant data on utilization, levels of uncompensated trauma care, and indicators of its quality.	As of July 2001, there was no Injury/Trauma Registry at DOH to which data were reported on a regular basis. An application by the Division of Injury and Violence for funding the Trauma Registry was submitted to the CDC in February of 2005.	Injury/Trauma Registry is established and legislation requiring regular reporting to DOH in effect.

Objective	Baseline	2010 Goal
7-3.1: Dropped 7-3.2: Dropped		
7-4.1.Promote wellness, health, and injury prevention within the community through public education programs and other initiatives.	This reflects ongoing activity. EHMSA is promoting injury prevention in collaboration with DOH/Injury Prevention.	Public education programs and other initiatives are in place in the community.
7-4.2. Define and expand the role of EMS in Public Health.	Since 2002, the role of EHMSA has been expanded to include emergency preparedness.	The role of EMS in Public Health has been expanded.
7-4.3. Support and promote EMS research on Public Health issues.	Since 2003, EMHSA has been applying statistical analysis to examine the quality of prehospital medical care.	EMS research in Public Health issues is promoted.
7-5. Revise and update existing legislation regarding public and private ambulance services relating to its delivery of effective EMS and transport between facilities.	Developmental	Existing legislation has been revised and updated.
7-6.Establish in the DOH EHMSA an Enforcement Division legislatively to ensure compliance with the DOH specified EMS rules and regulations.	Activity began after 2000 and was in place and staffed by 2003.	An Enforcement Division of the EHMSA is in place. *This goal was accomplished. Since 2003, an ambulance inspection and compliance officer has been on staff.*
7-7. Continue participation in the development and update of the District's Emergency Operations Plan for response to current and new threats to the District and surrounding jurisdictions.	This activity is ongoing.	The District's Emergency Operations Plan is in effect.

Focus Area: Health Care Finance *Access to care is a leading health indicator.*

Overview

Issues and Trends:

Nationally, the percentage of uninsured adults has increased over the last three years. Uninsured persons are disproportionately low income. Even with persons who are in the workforce, there is a decrease in employer coverage. For those who are working and have insurance, the premiums have gone up so that insurance costs more to retain. The increase in the uninsured accompanies an increase in Medicaid enrollment.

Disparities:

The increase in the uninsured is disproportionately higher in those adult persons under 200 percent of the poverty level. There was not the same type of increase in uninsured children, because of the SCHIP program, and regular Medicaid was able to pick up uninsured children. The health status disparities of persons on Medicaid mirror the health status disparities of the uninsured and minorities in the US. The financial disparities (as opposed to health status disparities) in the Medicaid program continue to be that the disabled and elderly constitute a disproportionately larger allocation of the Medicaid expenditures when compared to their percent of the eligible population.

Opportunities:

With these national trends as a backdrop, there are some local opportunities for the Medicaid program in DC through the **Medical Assistance Administration**. The expansion of the 50-64 waiver will allow DC to cover more of the single, childless adult population that has traditionally not had access to Medicaid benefits. Previously unspent funds from the DC SCHIP program are being repackaged through the HIFA waiver proposal to provide services to non-child populations. DC also has an opportunity to augment the traditional medical benefits package with mental health and substance abuse rehab option services to better address the behavioral health needs of the recipient population. There are also opportunities that shift the delivery of services from more costly institutionalized services to generally less costly settings in the home or community through the use of waivers for specific vulnerable recipient populations.

Revised 2010 Objectives for Health Care Finance

Insurance Coverage for Medicaid-eligible Pregnant Women and Children Up to 200 Percent of the Federal Poverty Level (FPL)

8-1: Reduce to less than 5 percent the proportion of Medicaid-eligible pregnant

women and children in families up to 200 percent of the poverty threshold that do not have health insurance coverage. **Baseline:** 8.5. percent of this targeted population was eligible but not enrolled in 1996.

Insurance Coverage for Adults without Minor Children Up to 200 Percent of the FPL

8-2: Establish insurance coverage for adults without minor children up to 50 percent of the federal poverty level (FPL) who do not have insurance. **Baseline:** The Medical Assistance Administration (MAA) has received approval from CMS for an 1115 Research and Demonstration Waiver to finance services for adults without minor children. Currently 1,208 persons are covered up to 50 percent of the FPL. Plans to modify the Waiver to include persons up to 100 percent of the FPL are on hold, because of funding constraints.

Insurance Coverage for Adults without Minor Children Up to 200 Percent of the FPL

8-3: Establish a comprehensive data reporting system or data warehouse to monitor the utilization of services and quality outcomes by contracted health plan, enrolled populations, and provider types. B**aseline:** The Medicaid Management Information System (MMIS) is based on 1970s technologies and is made up of a million lines of code and architecture based upon mainframe technology. The currently certified MMIS was procured by a new vendor in 2002. The MMIS architecture primarily supports a fee-for-service program as a payment engine and was not intended to serve as a comprehensive data reporting system. The new MMIS, to be procured in 2005, will do much more than just pay bills. It is an MAA expectation that the new MMIS will be modular and flexible with case management and reporting capabilities.

Rationale: The strategic role of Medicaid in the financing of services to vulnerable, uninsured populations is central to ensuring the overall health of all District residents. Measuring the impact and success of Medicaid's various programs and populations will take a more sophisticated system for the collection and manipulation of Medicaid data. The data warehouse will also serve as decision support system.

Increase in the Percentage of Temporary Assistance to Needy Families (TANF) Related Enrollees with a Specified Source of Primary Care

8-4: Increase to 95 percent the proportion of all TANF-related enrollees who have a specified source of ongoing primary care (i.e., a medical/health home). **Baseline**: In 1998 there were approximately 87 percent of all TANF enrollees who had a specified source of on-going primary care (e.g., being enrolled in one of the MAA-contracted managed care organizations (MCOs).

Rationale: Managed care is considered to be a viable way for Medicaid programs to cost-effectively provide primary care and related services for eligible individuals and families.

Increase the Participation of Medicaid-eligible Children in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

8-5: Increase to 80 percent the proportion of the Medicaid-eligible child population participating in the EPSDT Program. **Baseline**: Of the District's Medicaid-eligible child population, 40 percent participated in the EPSDT Program in 1998.

Creation of an Integrated Services Delivery System

8-6: Collaborate in the creation of an integrated services delivery system which ensures that Medicaid-eligible persons have access to comprehensive behavioral health services (i.e., substance abuse and mental health services). **Baseline:** In 2001, MAA received approval from CMS to finance mental health rehabilitation services for Medicaid eligible. For the past year (2004), MAA has been working with the Alcohol Prevention and Rehabilitation Services Administration (APRA) on a State Plan Amendment (SPA) to finance substance abuse treatment rehabilitation services. We expect the second SPA to move forward this year, so that ultimately both mental health and substance abuse rehab services will be available to Medicaid eligible.

Rationale: It is not cost-effective to provide fragmented care to persons needing behavioral health services. Services can be provided more cost effectively and coordinated better in an integrated system. Medicaid eligible persons currently have access to a range of mental health rehab services financed through DMH's Core Service Agencies. The future approval of the Substance Abuse SPA will enable Medicaid eligible persons to have access to comprehensive behavioral health services (e.g., both substance abuse and mental health services rehab services).

Ensure a Continuum of Long-term Care Services for Medicaid Eligible Needing Them

8-7: Ensure that Medicaid –eligible persons with long-term care needs have access to a continuum of long-term care services, including but not limited to nursing home care, home health care, adult daycare, and assisted living services. **Baseline:** 2000 figures are forthcoming on the number of persons on waivers; in nursing home care; in home health care; in adult daycare; and in assisted living services.

Rationale: This is a commitment shared with the Medicaid Office of Disabilities and Aging (DOA). The goal of the Medicaid ODA is to provide oversight and assistance for Medicaid individuals and providers seeking appropriate long-term care (LTC). As a component of this goal, an Aging and Disabilities Resource Center was officially opened on January 27, 2005 to provide easier access to a range of services for the elderly and disabled. ODA also seeks to increase the types of services and the capacity of those service options, so that individuals

can seek home and community-based services in the least restrictive and most appropriate level of care possible. The advent of the newly opened Aging and Disabilities Resource Center will also help to provide information and referral options, broker most appropriate levels of care and provide aid to families and individuals by streamlining the information and referral process, and assisting with the eligibility process. The outcome should be to increase the coordination of care and the numbers of persons seeking the most appropriate care and information that meets their LTC needs. ODA numerical goals are met: to increase the number of persons enrolled in the home and community-based elderly and physical disabilities waivers by 50 percent and as a result of waiver enrollments, to divert 5 percent of individuals from institutional care to home and community-based settings as a result of waiver enrollments. We seek to cost effectively increase the range of LTC options for older persons and persons with disabilities.

Comparable National Objectives

In the federal *Healthy People 2010 Plan* under Goal 1: Access to Quality Health Services, comparable objectives are the following:
1-1: Persons with health insurance
1-2: Health insurance coverage for clinical preventive services
1-6: Difficulties or delays in obtaining health care

Focus Area 8: Health Care Finance - Revised 2010 Objectives, Baselines and Goals

Objective	Baseline	2010 Goal
8-1. Reduce to less than 5 percent the proportion of Medicaid- eligible pregnant women and children in families up to 200 percent of the poverty threshold that do not have health insurance coverage.	8.3 percent of this targeted population was eligible but not enrolled in 1996. (*This is still the most recent estimate that we have available.)* *Source: Contractor estimate*	Less than 5 percent of eligible pregnant women and children in families up to 200 percent of the poverty threshold will go without health insurance coverage.

Objective	Baseline	2010 Goal
8-2. Establish insurance coverage for adults without minor children up to 50 percent of the federal poverty level (FPL) who do not have health insurance. MAA has received approval from CMS for an 1115 Research and Demonstration Waiver to finance services for adults without minor children.	Currently, 1,208 adults without minor children are covered up to 50 percent of the FPL. (*Plans to modify the Waiver to include persons up to 100 percent of FPL are on hold, because of funding constraints.*) Source: Reports from the Income Main-tenance Administration	Insurance coverage has been established for adults without minor children up to 50 percent of FPL who do not have health insurance.
8-3. Establish a comprehensive data reporting system or data warehouse to monitor the utilization of services and quality outcomes by contracted health plan, enrolled populations, and provider types.	The currently certified MMIS was procured by a new vendor in 2002. The new MMIS will do much more than just pay bills. It is an MAA expectation that the new MMIS will be modular and flexible with case management and reporting capabilities.	A comprehensive data reporting system or data warehouse has been established with which to monitor the utilization of services and quality outcomes by contracted health plan, enrolled populations, and provider types.
NOTE: MAA is in the process of developing a data reporting system known as a data warehouse system.	.	
8-4. Increase to 95 percent the proportion of all TANF related enrollees who have a specified source on ongoing primary care.	In 1998 there were approximately 89 percent of all TANF enrollees with a specified source of ongoing primary care (e.g., being insured in one of the MAA-contracted managed care organizations). Source: Medicaid Managed Care Reporting System	95 percent of all TANF enrollees have a specified source of ongoing primary care. *This goal has been met*. .

Objective	Baseline	2010 Goal
8-6. Collaborate in the creation of an integrated services delivery system which ensures that Medicaid eligible persons have access to comprehensive behavioral health services consisting of mental health and substance abuse service. In 2001, MAA received approval from CMS to finance mental health rehabilitation services for Medicaid eligible.	Since 2004, MAA has been working with APRA on a State Plan Amendment (SPA) to finance substance abuse treatment rehab services. We expect this second SPA to move forward this year, so that ultimately both mental health and substance abuse rehab services will be available to Medicaid eligible.	An integrated services delivery system has been created which ensures that Medicaid eligible persons have access to comprehensive behavioral health services consisting of mental health and substance abuse services.
8-7. Ensure that Medicaid eligible persons with long-term care needs have access to a continuum of long-term care services, including but not limited to nursing home care, home health care, adult daycare, and assisted living services.	The current numbers for persons on waivers as of 2000 in nursing home care, home health care, adult daycare, and assisted living services *are forthcoming.* (Source; Medicaid Office of Disabilities and Aging)	Medicaid-eligible persons with long-term care needs have access to a continuum of long-term care services, including but not limited to nursing home care, home health care, adult daycare, and assisted living services. .

Focus Area: Maternal, Infant and Child Health and Family Planning

Responsible sexual behavior is a leading health indicator.

Overview

Issues and Trends:

The health status of the District of Columbia rests largely with the health of its women, infants and children. As a significant portion of the population, this groups serves as a primary predictor of the health of future generations. Several indicators capture the status of maternal, infant and child health. These range from those affecting pregnant and post-partum women to those affecting infant survival. The overall health and wellness of a community can largely be determined by its infant mortality. Over the past 15 years, the infant mortality rate in the District of Columbia has decreased by 42.5 percent. While a marked increase occurred in 1999 and a slight increase occurred in 2002, the District's infant mortality rate has steadily declined consistently with national infant mortality trends. The District's rate, however, remains significantly higher than the national rate of 7.0 per 1,000 live births.

Four causes account for more than half of the District's infant deaths: Maternal complications of pregnancy, birth defects, complications of placenta, cord and membranes, and disorders related to short gestation and low birth weight. Other factors contributing to infant mortality are prenatal care, race, and age of mother, and ward of residence.

Disparities:

Despite notable progress in medical advancement, persistent disparities in the burden of illness and mortality experienced by African Americans, Hispanics, American Indians, Alaskan Natives, Asians, and Pacific Islanders remain. These ethnic and racial groups are disproportionately overrepresented in women's reproductive health disparities. Across racial and ethnic boundaries, women are more likely than men to live in poverty. Women of color have long been beset by an array of obstacles to reproductive health care services that places their overall health at risk. Socioeconomic issues associated with poverty and lack of insurance are among the leading obstacles often cited. Because women of color are less likely than white women to receive adequate reproductive healthcare, they are more likely to experience negative health outcomes including maternal and infant mortality.

Many of the conditions and risk factors associated with infant mortality in the District of Columbia disproportionately affect women of color. The disparities between white and nonwhite racial and ethnic groups in the reference issue areas are vast and in many cases continue to grow. While overall key indicators continue to decline, the vacuum between racial groups persists. The percentage of LBW among births to black mothers

is 14.6 percent, which is more than twice the percentage of 6.1 percent for white mothers.

Opportunities:

Several of the aforementioned risk factors can be mitigated by good prenatal and preconception healthcare. Both preconception screening and counseling offer opportunities for identification and prevention of maternal risk factors prior to onset of pregnancy. Preconceptional counseling also offers the opportunity for providers to refer women for medical and psychological support services for risk factors that may be identified. Prenatal care presents opportunities to educate women about the adverse effects of alcohol, tobacco and substance usage, as well as the benefits of daily folic acid consumption. Increased usage of quality prenatal care can prevent poor birth outcomes and ultimately improve maternal health by identifying risk behaviors and controlling for those behaviors. Interventions targeting prevention may further reduce low birth weight and preterm delivery rates.

Interventions taken post birth also offer new opportunities to improve infant health and survival. Breastfeeding has been shown to reduce infection rates in infants and to improve long-term maternal health. Sudden infant death syndrome (SIDS) may also be preventable. Placing babies on their backs to sleep has been shown to reduce the prevalence of SIDS.

Revised 2010 Objectives for Maternal, Infant and Child Health and Family Planning

Infant Mortality Rate

9-1: Reduce the infant mortality rate to no more than 8 deaths per 1,000 live births. **Baseline:** The infant mortality rate was 11.9 per 1,000 live births in 2000.

Rationale: Infant mortality is a marker for the overall health of a community. Between 1992 and 2001, the infant mortality rate has dropped by 42.1 percent in the District of Columbia. However, great disparities still exist between resident minority racial and ethnic population groups and the white population in this area.

Sudden Infant Death Syndrome

9-2: Reduce the Sudden Infant Death Syndrome (SIDS) mortality rate to 0.3 per 1,000 live births. **Baseline**: The SIDS mortality rate in the District was 1.2 per 1,000 live births in 2000.

Child Mortality

9-3: Reduce the rate of child mortality to 30 per 100,000 children ages 1-4 years and 20 per 100,000 children ages 5-14 years. **Baseline**: Overall, the child mortality rate in the District was 58.3 per 100,000 children ages 1-4 and 18.3 per 100,000 children ages 5-14 in 2000.

Fetal Death Rate

9-4: Reduce the fetal death rate to no more than 6 deaths per 1,000 live births plus fetal deaths. **Baseline**: The fetal death rate in the District was 11.0 per 1,000 live births plus fetal deaths in 2000.

Maternal Mortality

9-5: Reduce the maternal mortality rate to no more than 0.9 per 10,000 live births. **Baseline**: There were 1.3 maternal deaths in the District per 10,000 in 2000 (which is equivalent to one maternal death).

Early Prenatal Care

9-6: Increase to at least 80 percent the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy. **Baseline**: 75.3 percent of mothers of live-born infants began prenatal care in the first trimester in 2000.

Rationale: Several barriers to accessing prenatal care have been identified through the years. These include inadequate transportation and childcare services, the systemic inadequacy in recruiting hard-to-reach women, and the lack of insurance to pay for prenatal care. Other factors have also contributed to women not obtaining care early, including lack of information about the importance of early care and dissatisfaction with health care providers. In addition, great disparities exist between racial and ethnic groups, with African American women being least likely to obtain care in the first trimester when compared to their white counterparts.

9-7: Deleted

Very Low Birth Weight Babies

9-8: Increase to 90 percent the proportion of very low birth weight infants born at Level III hospitals. **Baseline**: 71.2 percent of very low birth weight babies were born at Level III hospitals in 2002.

Caesarean Delivery Rate

9-9: Reduce the cesarean delivery rate to no more than 15 per 100 deliveries. **Baseline**: The rate for cesarean deliveries was 22.6 per 100 deliveries in 2000.

Low Birth Weight and Very Low Birth Weight Babies

9-10: Reduce low birth weight to an incidence of no more than 6 percent of live births and very low birth weight to no more than 2 percent of live births. **Baseline**: The rate of low birth weight was 11.9 percent in 2000; and the rate for very low birth weight was 2.6 percent in 2000.

Preterm Births

9-11: Reduce the incidence of preterm births to 100 per 1,000 births. **Baseline**: The preterm birth incidence rate was 132.0 per 1,000 live births in 2000.

Adequate Weight Gain during Pregnancy

9-12: Increase the proportion of mothers who achieve a weight gain that is consistent with the Institute of Medicine guidelines during their pregnancies. **Baseline**: 73.4 percent of expectant mothers achieved an adequate weight gain in 2001 according to the Pregnancy Risk Assessment Monitoring and Surveillance (PRAMS) data.

Infants Put to Sleep on Their Backs

9-13: Increase to 90 percent the proportion of infants who are put to sleep on their backs. **Baseline**: 60.1 percent of infants were put to sleep on their backs, according to PRAMS 2001 data.

Abstinence from Alcohol Use during Pregnancy

9-14: Increase abstinence from alcohol use by pregnant women to 99 percent. **Baseline:** 98.7 percent of birth mothers abstained from alcohol use in 2000. (Source: SCHSA)

Abstinence from Tobacco Use during Pregnancy

9-15: Increase abstinence from tobacco use by pregnant women to 98 percent. **Baseline:** 97.3 of birth mothers abstained from tobacco use in 2000. (Source: SCHSA)

Fetal Alcohol Syndrome

9-16: Eliminate the incidence of fetal alcohol syndrome (FAS). **Baseline:** Incidence of FAS was 0.0 percent of births in the District in 2000. (Source: SCHSA)

Breastfeeding during the Early Postpartum Period

9-17: Increase to at least 40 percent the proportion of mothers who breastfeed their babies in the early postpartum period. **Baseline**: 58 percent of mothers breastfed their babies in the early postpartum period in 2002 according to PRAMS data.

Breastfeeding Exclusively

9-18: Increase to at least 70 percent the proportion of women whose infants are breastfed exclusively. **Baseline:** 51 percent of mothers breastfed exclusively in 2003 according to PRAMS data.

Screening Newborns for Hearing Loss

9-19: Increase to 100 percent the proportion of newborns who are screened for hearing loss by 1 month of age, have diagnostic follow-up by 3 months, and are enrolled in appropriate intervention services by 6 months. **Baseline**: In 2003, 98.0 percent of all newborns born in District hospitals were screened for hearing impairments before hospital discharge.

Planned Pregnancies

9-20: Increase to at least 55 percent the proportion of all planned pregnancies among women ages 15-44. Baseline: 51 percent of pregnancies were unintended – either unwanted or earlier than desired – in 2002.

9-21: Deleted

Pregnancy in Females Ages 15-17

9-22: Reduce pregnancies among females ages 15-17 to no more than 107 per 1,000 pregnancies. **Baseline**: There were 75.3 pregnancies per 1,000 females ages 15-17 in 2000. (Source: SCHSA)

Adolescents Engaging in Sexual Intercourse before the Age of 15

9-23: Reduce to no more than 12 percent the proportion of young people 15-19 who have engaged in sexual intercourse before the age of 15. **Baseline:** 15 percent

of young people in grades 9-12 reported having had sexual intercourse for the first time before age 13 according to the 2003 DCPS Youth Risk Behavior Survey (YRBS).

Teens (15-17) Ever Engaging in Sexual Intercourse

9-24: Reduce to no more than 50 percent the proportion of young people ages 15-17 who have ever had sexual intercourse. **Baseline**: 63.9 percent of young people in grades 9-12 reported that they had sexual intercourse according to the 2003 YRBS.

9-25: Deleted
9-34: Deleted

Prevalence of Chlamydia trachomatis among Young People (15-24)

9-35: Reduce the prevalence of Chlamydia trachomatis among young people ages 15-24 to no more than 3.0 percent. **Baseline**: To be dropped for lack of reliable data source.

Comparable National Objectives

In the federal *Healthy People 2010 Plan*, comparable objectives are the following:
Comparable objectives from the federal *Healthy People 2010 Plan* are the following:
16-1: Fetal and infant deaths
16-4: Maternal deaths
16-6: Prenatal care
16-8: Very low birth weight infants born at Level III Hospitals
16-9: Cesarean births
16-10: Low birth weight and very low birth weight
16-11: Preterm births
16-12: Weight gain during pregnancy
16-13: Back to Sleep
16-17: Prenatal Substance Exposure
16-18: Fetal Alcohol Syndrome
16-19: Breastfeeding

Focus Area 9: Maternal, Infant and Child Health and Family Planning - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
9-1.Reduce the infant mortality rate to no more than 8 deaths per 1,000 live births.	The infant mortality rate was 11.9 per 1,000 live births in 2000 (SCHSA).	The infant mortality rate has been reduced to no more than 8 per 1,000 live births.

Objective	Baseline	2010 Goal
9-2. Reduce the Sudden Infant Death Syndrome (SIDS) mortality rate to 0.3 per 1,000 live births.	The SIDS mortality rate in the District was 1.2 per 1,000 in 2000 (SCHSA).	The SIDS death rate for this year is 0.3 per 1,000 live births.
9-3. Reduce the rate of child mortality to 30 per 100,000 children ages 1-4 and 20 per 100,000 children ages 5-14.	Overall, the child mortality rate in the District was 58.3 per 100,000 children ages 1-4; and 18.3 per 100,000 children ages 5-14 in 2000. (SCHSA).	The child mortality rate has been reduced to 30 per 100,000 children ages 1-4; 20 per 100,000 children ages 5-14.
9-4. Reduce the fetal death rate to no more than 6 deaths per 1,000 live births plus fetal deaths.	The fetal death rate in the District was 11.0 per 1,000 live births plus fetal deaths in 2000 (SCHSA).	The fetal death rate has been reduced to no more than 6 deaths per 1,000 live births plus fetal deaths.
9-5. Reduce the maternal mortality rate to no more than 0.9 per 10,000 live births.	There were 1.3 maternal deaths in the District per 10,000 in 2000 (which is equivalent to one maternal death)(SCHSA).	There will be no more than 0.9 maternal deaths per 10,000 live births.
9-6. Increase to at least 80 percent the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy.	75.3 percent of mothers of live-born infants began prenatal care in the first trimester in 2000 (Source:).	80 percent of all pregnant women begin prenatal care in the first trimester of pregnancy.
9-7. Dropped		
9-8.Increased to 90 percent the proportion of very low birth-weight infants born at Level III hospitals.	71.2 percent of very low birth-weight babies were born at Level III hospitals in 2002.	90 percent of very low birth-weight infants will be born at Level III hospitals.
9-9. Reduce the cesarean delivery rate to no more than 15 per 100 deliveries.	The rate for cesarean deliveries was 22.6 per 100 deliveries in 2000 (Source:).	The rate for cesarean deliveries has been reduced to no more than 15 per 100 deliveries.
9-10. Reduce low birth-weight to an incidence of no more than 6 percent of live births and very low birth-weight to no more than 2 percent of live births.	The rate of low birth-weight was 11.9 percent in 2000 and the rate for very low birth-weight was 2.6 percent in 2000 (SCHSA).	The incidence of low birth-weight has been reduced to no more than 6 percent of live births and that of very low birth-weight to no more than 2 percent of live births.

Objective	Baseline	2010 Goal
9-11. Reduce the incidence of preterm births to 100 per 1,000 births.	The preterm birth incidence rate was 132.0 per 1,000 live births in 2000 (Source: SCHSA).	Public education programs and other initiatives are in place in the community.
9-12. Increase the proportion of mothers who achieve a weight gain that is consistent with the Institute of Medicine (IOM) guidelines during their pregnancies..	73.4 percent in 2001 according to Pregnancy Risk Assessment Monitoring and Surveillance (PRAMS) data.	An increased proportion of mothers achieves a weight gain that is consistent with the IOM guidelines.
9-13. Increase to 90 percent the proportion of infants who are put to sleep on their backs.	60.1 percent according to PRAMS 2001 data.	Proportion of infants put to sleep on their backs has increased to 90 percent.
9-14.Increase abstinence from alcohol use by pregnant women to 99 percent.	98.7 percent of birth mothers abstained from alcohol use in 2000 (Source: SCHSA).	Abstinence from alcohol use by pregnant women has increased to 99 percent.
9-15. Increase abstinence from tobacco use by pregnant women to 98 percent.	97.3 percent of birth mothers abstained from tobacco use in 2000(Source: SCHSA).	Abstinence from tobacco use by pregnant women will be increased to 98 percent.
9-16. Eliminate the incidence of fetal alcohol syndrome (FAS).	Incidence of FAS was 0.0 percent of births in 2000 (Source: SCHSA).	Incidence of FAS will be eliminated.
9-17. Increase to at least 40 percent the proportion of mothers who breast-feed their babies in the early postpartum period.	58 percent in 2002 according to PRAMS data.	40 percent of mothers breast-feed their babies in the early postpartum period.
9-18.increase to at least 70 percent the proportion of women whose infant are breast-fed exclusively.	51 percent in 2003 according to PRAMS data.	At least 70 percent of women breast-feed their infants exclusively.
9-19. Increase to 100 percent the proportion of newborns who are screened for hearing loss by 1 month of age, have diagnostic follow-up by 3 months, and are enrolled in appropriate intervention services by 6 months.	In 2003, 98.0 percent of all newborns born in District hospitals were screened for hearing impairments before hospital discharge.	100 percent of newborns are screened for hearing loss by 1 month of age, have diagnostic follow-up by 3 months, and are enrolled in appropriate intervention services by 6 months.

Objective	Baseline	2010 Goal
	Family Planning	
9-20. Increase to at least 55 percent the proportion of all planned pregnancies among women ages 15-44.	51 percent of pregnancies were unintended – either unwanted or earlier than desired – in 2002.	At least 55 percent of all pregnancies among women ages 15-44 are planned.
9-21. Deleted.		
9-22. Reduce pregnancies among females ages 15-17 to no more than 107 per 1,000 pregnancies.	There were 75.3 pregnancies per 1,000 females ages 15-17 in 2000 (Source: SCHSA).	Pregnancies among females 15-17 are reduced to no more than 107 per 1,000 adolescents.
9-23. Reduce to no more than 12 percent the proportion of young people ages 15 – 19 who have engaged in sexual intercourse before than age of 15.	15 percent of young people in grades 9-12 reported having had sexual intercourse for the first time before age 13, according to the 2003 DCPS Youth Risk Behavior Survey (YRBS).	No more than 12 percent of young people ages 15-19 have engaged in sexual intercourse before the age of 15.
9-24. Reduce to no more than 50 percent the proportion of young people ages 15-17 who have ever had sexual intercourse.	63.9 percent of young people in grades 9-12 reported that they had sexual intercourse, according to the 2003 YRBS.	No more than 50 percent of young people ages 15-17 have ever had sexual intercourse.
9-25. Deleted		
9-34. Deleted (a repeat of 9-23)	.	
9-35. Reduce the prevalence of Chlamydia trachomatis among young people ages 15-24 to no more than 3.0 percent.	To be dropped for lack of reliable data source.	Prevalence of Chlamydia trachomatis among young people ages 15-24 is no more than 3.0 percent.

Focus Area: Public Health Infrastructure

Overview

Issues and Trends:

Creating a strong network that continues to define shared data standards to support the exchange of key health data is critical for a more effective and response-oriented public health system. The Public Health Infrastructure will serve as the framework supporting a system better positioned to respond to the changing needs of public health and consequently the District.

Disparities:

Currently there are multiple systems in place that support communications for public health labs, the clinical community, and state and local health departments. Each has demonstrated the importance of being able to exchange health information. However, many of these systems operate in isolation, not capitalizing on the potential for a cross-fertilization of data exchange. A crosscutting and unifying framework is needed to better monitor these data streams for early detection of public health issues and emergencies.

Opportunities:

The Public Health Infrastructure provides the framework to meet these challenges. Through defined data and vocabulary standards and strong collaborative relationships, the Public Health Infrastructure will enable consistent exchange of response, health, and disease tracking data between public health partners and dissemination and access by citizens. Ensuring the security of this information is also critical as is the ability of the network to work reliably in times of national crisis. A robust Public Health Infrastructure consists of five key components: detection and monitoring, data analysis, knowledge management, alerting and response:

1) Detection and monitoring of disease and threat surveillance, national health status indicators;
2) Analysis that facilitates real-time evaluation of live data feeds, turning data into information for people at all levels of public health;
3) Information resources and knowledge management capabilities that provide intuitive access to reference materials, integrated distance learning content and decision support;
4) Alerting and communications features that enable emergency alerting, routine professional discussions and collaborative activities; and
5) Response: management support of recommendations, prophylaxis, vaccination, among others.

Revised 2010 Objectives for Public Health Infrastructure

Increased Onsite Access to Data

10-1.1: Increase to 90 percent the proportion of DOH agencies that provide onsite access to data via electronic systems and online information systems, such as the Internet . **Baseline**: Zero in 1997. DOH agencies had no access to the Internet at this time. By 2001, this goal had been met. All of the major sites at DOH, around 1200 employees, are connected via electronic systems and online information systems and have internet access.

Development of an Integrated information System for DOH (revised in 2003)

10-1.2: Develop and implement a departmental intranet for the DOH. **Baseline:** Components of the departmental intranet for DOH were 10 percent complete in 2001. As of December 2004, work on the DOH intranet was 50 percent complete.

Rationale: A departmental intranet is needed to improve communications and to serve as an information source for DOH office, programs and staff.

Use of Electronic Technology for DOH Programs (revised in 2003)

10-1.3: Implement wireless communication capability for Bioterrorism Preparedness and other communications requirements. **Baseline**: The process was begun in 1997 and about 40 percent of the planned components were installed as of 2003.

Rationale: Wireless communications are extremely important to help assure communications during a Bioterrorism threat or other critical event. Staff must have use of and access to wireless devices, such as pagers and personal digital assistant to communicate in the event of an emergency.

10-2: Dropped

Health Datasets on all Resident Racial/Ethnic Minority Population Groups in the District of Columbia (revised in 2004)

10-3: Develop health baseline datasets for all resident racial/ethnic minority population groups in the District of Columbia. **Baseline**: As of mid 1989, Vital Records data on race of residents were collected according to three broad categories (black, whites, and other), as well as Hispanic ethnicity, and cited in reports produced by the SCHSA. In 2004, in a randomized household survey of a representative sample of the resident Latino community, health baseline data on this resident population group were collected in a community partnered research

study entitled the "Latino Health Care Collaborative." This study represents the first application of a model for community health assessment and data-driven community health education that was developed by the **DOH State Center for Health Statistics Administration (SCHSA)** for application in resident minority populations, such as the Latino population of the District, in collaboration with the George Washington University Center for Global Health and the Coalition of Latino Agencies.

Rationale: Databases on each of the racial/ ethnic population groups residing in the District are essential for the identification and tracking of health disparities and of any progress made in the elimination of the disparities. These databases should include definitive data that reflect the health priorities and disparities experienced by each of the resident minority population groups or subgroups.

Tracking of *DC Healthy People 2010 PLAN* Objectives Annually (revised in 2001)

10-4: Produce annual or biennial implementation plans with short-term targets to evaluate goal-seeking strategies for the District's *Healthy People 2010* Objectives. **Baseline:** Beginning in 2001, with the development of the Annual Implementation Plan for 2001-2002, progress in attaining short-term targets has been tracked annually or biennially (as in the 2003-2005 plan) for over 80 percent of the 2010 Objectives and reported in the companion Progress Report.

Geographic Information Systems (GIS) Health Profiles of Select Population (Minority) Subgroups Residing in the District of Columbia Based on Geocoded Datasets (revised in 2001)

10-5: Increase to 50 percent the use of geocoding in all DOH data systems to promote the development of Geographic Information Systems (GIS) capabilities. **Baseline:** About 10 percent of DOH agencies were using GIS in 1997.

Rationale: GIS in Public Health encompasses the design, development and utilization of GIS tools for the description of health situations, epidemiological analysis and public health management. The abilities of GIS to integrate and process data contribute to its potential for application in different areas of public health. Some of the main application areas of GIS in health are: the spatial distribution of a health event; the identification of environmental and occupational risks; health situation analysis in a geographic area; identification of high risk groups and critical areas; public health surveillance and monitoring; the generation of research hypothesis; and the planning, programming and management of health activities. Thus, GIS offers enormous potential for improving health services and assisting in eliminating health disparities. DOH programs are encouraged to employ GIS by organizing, using and distributing spatial information and thereby making the achievement of the *DC Healthy People 2010* goals more realistic.

Provision of Comprehensive Epidemiology Services to Support Essential Public Health Services

10-6: Increase to 20 percent the proportion of DOH agencies that ensure the provision of comprehensive epidemiology services to support essential public health services. **Baseline**: 10 percent of DOH agencies provided comprehensive epidemiology services to support essential public health services in 1999. Since 2003, this goal has been attained.

Summary Measures of Population Health and the Public Health Infrastructure (revised in 2004)

10-7: Increase to 80 percent the proportion of DOH agencies that use summary population health measures for each of the focus areas in the District's Healthy People 2010 Plan to monitor progress in residential communities and for planning purposes. **Baseline**: 50 percent of agencies were providing summary population measures for the District's *Healthy People 2010 Plan* by 1997. Since 2002, this goal has been attained.

Comparable National Objectives

In the federal *Healthy People 2010 Plan*, comparable objectives are the following:
23-1: Public health employee access to the Internet
23-2: Public access to information and surveillance data
23-3: Use of geocoding in health data systems
23-4: Data on all population groups
23-5: Data for Leading Health Indicators, Health Status Indicators, and Priority Data Needs at ….State level
23-6: National tracking of *Healthy People 2010* objectives
23-12: Health Improvement Plans
23-13: Access to public health laboratory services
23-14: Access to epidemiology services

Focus Area 10: Public Health Infrastructure - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
10-1.1. Increase to 90 percent the proportion of DOH agencies that provide onsite access to data via electronic systems and online information systems, such as the Internet.	Zero in 1997. DOH agencies had no access to the Internet at this time. *By 2001, this goal had been met. All o the major sites at DOH – around 1200 employees are connected via electron systems and online information syste and have internet access. (Source: SCHSA)*	90 percent of DOH agencies provide onsite access to data via electronic systems and online information systems. *Met by 2001.*

Objective	Baseline	2010 Goal
10-1.2. *Revised in 2003*: Develop and implement a departmental intranet for the DOH.	Components of the departmental intra for DOH were 10 percent complete in 2001. *As of December 2004, work or DOH intranet will be 50 percent comp*	DOH has a departmental intranet.
10-1.3 *Revised in 2003:* Implement wireless communication capability for Bioterrorism Preparedness and other communications requirements.	The process was begun in 1997 and about 40 percent of the planned components were installed as of 2003	Wireless communication capability for Bioterrorism preparedness and other communications requirements is in place.
10-2: Dropped		
10-3. *Revised in 2001 to*: Develop health baseline datasets on all resident racial/ethnic minority population groups in the District of Columbia (black/African American, white, Hispanic/Latino, Asian American/Pacific Islander, American Indian/ Alaska Native. Objectives	As of mid 1989, Vital Records data on race of residents were collected according to three broad categories (black, white, and other, as well as Hispanic ethnicity) and cited in reports produced by the SCHSA. *In 2004, in a randomized, household survey of a representative sample of the resident Latino community. Health baseline data on this resident population group were collected in a community partnered research study, the Latino Health Care Collaborative. This study is the first application of a model for community health assessment and data-driven community health education that was developed for the DC Community Health Assessment Initiative (DC CHAI) by the SCHSA in 20027.*	Data are accessible at the SCHSA on all of the major population groups residing in the District of Columbia.
10-4. *Revised on 2001*: Produce annual or biennial implementation plans with short-term targets to evaluate goal- seeking strategies for the District's *Healthy People 201*0 Objectives.	Beginning in 2001, with the development of the Annual Implementation Plan for 2001-2002, progress in attaining targets has been tracked annually or biennially for over 60 percent of the 2010 Objectives and reported in the companion Progress Report.	Annual or Biennial implementation Plans are produced and made available to the public on schedule.

Objective	Baseline	2010 Goal
10-5. Increase to 50 percent the use of geocoding in all DOH data systems to promote the development of Geographic Information Systems (GIS) capabilities.	About 10 percent of DOH agencies were using GIS in 1997.	Use of geocoding in all DOH data systems to promote the development of Geographic Information Systems (GIS) capabilities has been increased to 50 percent.
10-6. Increase to 20 percent the number of DOH agencies that ensure the provision of comprehensive epidemiology services to support essential public health services.	10 percent in 1999. *Since 2003, this goal has been attained.*	20 percent of DOH agencies ensure the provision of comprehensive epidemiology services to support essential public health services.
10-7. *Revised in 2004*: Increase to 80 percent the proportion of DOH agencies that use summary population health measures for each of focus areas in the District's *Healthy People 2010 Plan* to monitor progress in residential communities and for planning purposes.	50 percent of agencies were providing summary population measures for the District's *Healthy People 2010 Plan* by 1997. *Since 2002, this goal has been attained.*	80 percent of DOH agencies use summary population health measures to monitor progress in residential communities and for use in the planning of public health services.

Prevent and Reduce Diseases and Disorders

11. Asthma
12. Cancer
13. Diabetes
14. Disabilities
15. Cardiovascular Diseases (formerly Heart Disease and Stroke)
16. HIV/AIDS
17. Immunization
18. Mental Health
19. Sexually Transmitted Diseases
20. Substance Abuse
21. Tuberculosis

Focus Area: Asthma

*Environmental quality is a leading health indicator***.**

Overview

Issues and Trends:

Asthma is a chronic disorder that inflames and constricts airways, making breathing difficult. Symptoms include recurrent coughing, wheezing, shortness of breath or rapid breathing, and chest tightness, which may be exacerbated by environmental factors (triggers), such as tobacco smoke, dust, pollen, pests, stress, and others. Asthma is unique in that it is a multi-faceted disease that is associated with familial, socioeconomic, and environmental factors. It is unknown to the scientific community exactly how these factors interact to cause asthma. What is known is that asthma can be managed. Morbidity due to asthma is preventable; deaths from asthma should not occur.

Statistically the District of Columbia has one of the nation's highest asthma prevalence rates based on the Behavioral Risk Factor Surveillance System (BRFSS). Compared to neighboring states, prevalence rates are higher in the District than in Maryland and Virginia, and higher than in the US in general.

Disparities:

Approximately one out of nine adults in the District suffers from asthma. The 2002 BRFSS survey indicated that 9.1 percent of District adults, or approximately 42,000 adult residents have asthma. Asthma affects District residents of all ages, races, and ethnic groups. Young children in low-income and minority populations have been most severely impacted by this chronic disorder. However, asthma has been increasing in the adult population. The prevalence of asthma is highest in minority populations based on the three data sources used in the "Asthma in the District of Columbia" report. As seen in the BRFSS, the lower income and education levels have higher rates of asthma, but strikingly the higher age group (65+) in year 2002 surpassed all other age groups. In addition, data show that of all the age groups, the young and the elderly suffer the most from asthma. Increased hospitalizations and asthma prevalence rates are the hallmark of the younger age group. The oldest age group predominantly experiences the highest mortality rate. The number of emergency department (ED) visits made by DC children aged 12 months to 17 years (inclusive) increased from 3,830 in 2002 to 4,776 in 2003. 42.9 percent of these visits were made by children aged 12 months – 4 years; and males made 59.7 percent of the visits. Little data have been collected on adults who use the ED for care.

Opportunities:

In 2001, the District of Columbia Department of Health (DOH) launched the **DC Control Asthma Now (DC CAN) Program** to develop a viable, comprehensive, community-based, consumer-centered approach to asthma diagnosis and management to meet the District's 2010 asthma objectives and to improve the quality of life for District residents who suffer from asthma. An Asthma Strategic Plan was

completed in 2004, and its Implementation will expand asthma care and surveillance capacity and produce data to enable the District to achieve more optimal levels of effectiveness and efficiency in the use of available care delivery resources. The following short list explains major objectives:

- Develop interventions to reduce asthma hospitalizations, deaths, and emergency department visits, especially for the high-risk population (seniors, children, blacks, and Hispanics).
- Identify barriers in the delivery of asthma care services particularly to the underserved and high-risk groups.
- Increase education and awareness programs that are culturally sensitive and linguistically appropriate for all races and differing socioeconomic status.
- Promote the use of the National Institutes of Health (NIH) National Heart, Lung, and Blood Institute's (NHLBI) guidelines.
- Educate persons with asthma and their family members, as well as providers and health educators.
- Strengthen asthma surveillance.

DC CAN embraces the view of asthma experts that the approach to asthma prevention and control should include: a better physician/patient partnership; effective education for both providers and patients regarding the factors associated with asthma; proper medical management; and policies that support people with asthma and their rights to use their medications in public and private settings.

Revised 2010 Objectives for Asthma

Reduction in Asthma Mortality Rate

11-1: Reduce the asthma mortality rate to no more than 1.5 per 100,000 population. **Baseline**: The age-adjusted asthma mortality rate was 1.74 per 100,000 population in the District of Columbia for all ages in 2000. (Data Collection and Analysis Division of MFHA and SCHSA)

Reduction in the Asthma Morbidity Rate as Measured by a Reduction in the Hospitalization Rate for Asthma

11-2: Reduce the overall asthma morbidity as measured by a reduction in the asthma hospitalization rate to 10 per 10,000 population. **Baseline**: The asthma hospitalization rate was 22 per 10,000 population in 2000.

Reduction in Asthma Morbidity Rate as Measured by a Reduction in ER Visits

11-3: Reduce the annual rate of Emergency Department visits to no more than 46 per 10,000 population. **Baseline**: to be added.

Comparable National 2010 Objectives

Comparable objectives from the federal *Healthy People 2010 Plan* are the following:
24-1: Deaths from asthma
24-2: Hospitalization for asthma
24-3: Hospital emergency department visits for asthma
24-6: Patient education

Focus Area 11: Asthma - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
11-1.Reduce the asthma mortality rate to no more than 1.5 per 100,000 residents.	Asthma mortality rate was 2.8 per 100,000 population in the District for all ages in 1997. (non-age adjusted figures)(Data Collection and Analysis Division of MFHA and SCHSA)	Asthma mortality rate has declined to no more than 1.5 per 100,000.
11-2. Reduce the overall asthma morbidity, as measured by a reduction in the asthma hospitalization rate to 10 per 10,000 people.	Asthma hospitalization rate was 27 per 10,000 for all ages in 1998; 22 per 10,000 in 2000. (DC Hospital Association provided data; calculation by DC CAN)	The asthma hospitalization rate has been reduced to 10 per 10,000 people.
11-3. Reduce the annual rate of Emergency Department (ED) visits to no more than 80 per 10,000 DC ages 0-4 children (CDC 2010 goal).	The ED rate for children ages 0-4 years was 745.7 visits per 10,000 children in 2003. (Source: Improving Pediatric Asthma care in the District of Columbia or IMPACT DC)	Annual rate of ED visits is no more than 80 per 10,000 DC children 0-4 years in age.

Focus Area: Cancer – Breast, Cervical, and Prostate Cancer and Registry

Overview

Breast and Cervical Cancer:

Issues/ Trends:

The incidence of breast cancer has continued to rise since the early 1980s. Much of the increase in incidence can be attributed to greater use of mammography screening and the increased detection of smaller tumors. There has been an important reduction in female death rates from breast cancer in recent years, mostly due to improvements in treatment and early detection. In 2000, more than seventy percent of women ages 40 and older reported having a mammogram in the past two years. Cervical cancer incidence and mortality rates have decreased markedly in the past several decades, with most of the success attributed to widespread use of the Pap test for screening. Cervical cancer is now one of the most successfully treatable cancers. In 2000, more than eighty percent of women reported having a Pap test within the past three years.

Disparities:

Health care disparities pervade all aspects of screening, diagnosis, and treatment of breast and cervical cancer. African American women have the highest death rates in the United States from both breast and cervical cancer. Similarly, African American or black women have lower stage-specific survival rates from breast and cervical cancer than do white women. Other disparities include low utilization of Pap test screenings for cervical cancer by Asian/ Pacific Islander women and low utilization of mammography screening for breast cancer by American Indian/ Alaskan Native women. National data on Latino women have shown that despite having a lower incidence rate of breast cancer, Latinas have a higher mortality rate often attributed to disparities in access to health and culturally competent delivery of services. Socioeconomic disparities also lead to poorer outcomes in breast and cervical cancer. Women who lack health insurance are significantly less likely to report ever having a mammogram; and women who have been living in the United States for less than ten years are less likely to report ever having a Pap smear. Current tracking and reporting mechanisms in the District do not provide sufficient data on ethnic and racial groups.

Opportunities:

Opportunities for breast and cervical cancer control exist in screening, diagnosis and treatment. Innovative ways of facilitating communication between patient and provider, such as computer-generated tailored invitations for screening, will increase the ease with which physicians make referrals for mammograms and Pap tests. Opportunities for improved diagnostic services include digital technology in the diagnosis of breast cancer, the development of liquid-based Pap test technology, and easily accessible HPV testing in

the diagnosis of cervical cancer. Treatment opportunities include multi- disciplinary treatment programs and new research aimed at prohibiting molecular targets involved in cancer progression. New anti-cancer drugs showing promise in the treatment of advanced breast cancer enable providers to develop more personalized treatment regimens based upon a patient's needs. Short-term research on HPV vaccines has proved a promising opportunity to prevent HPV infection and subsequent cervical cancer.

Increased awareness on ethnic and racial disparities and the lack of data to measure such disparities has brought to the forefront the need to establish a baseline and reporting mechanisms that include racial and ethnic categories.

The **Department of Health Project WISH** – part of the federally funded Breast and Cervical Early Detection Program (BCCEDP) – will continue providing education and free screening services to eligible women. The program targets uninsured women ages 50-64 with limited income, The District's emphasis on access to the uninsured – via the DC Healthcare Alliance – and the infusion of funds for the exploration of the "Medical Homes" model provide Project WISH with unique opportunities to assure coordinated care that includes screening and monitoring.

Revised 2010 Objective for Lung Cancer

12-1: Reduce the mortality of cancer of the lung and bronchus to no more than (goal to be added) per 100,000 population. Baseline: The age-adjusted mortality rate for lung and bronchus cancer in the District was 59.1 in 2000; nationally the age-adjusted mortality rate for lung and bronchus cancer was 41.2 in 2000.

Note: Although there is no program to support interventions for this objective as of 2005, it has been revised to address lung and bronchus cancer to conform with the cancer mortality rates as reported by CDC.

Revised 2010 Objectives for Breast and Cervical Cancer

Breast Cancer Mortality

12-2.1**:** Reduce breast cancer mortality to an age-adjusted death rate of no more than 24.4 per 100,000 population. **Baseline:** The age- adjusted breast cancer mortality rate in DC was 27.0 per 100,000 population in 2000 (Cancer Incidence and Mortality Report).

Rationale: Clinical breast examinations and mammograms can detect cancer early and reduce mortality. Approximately 36,000 women are uninsured or underinsured in the District. Of these women, 13,000 are in the 40-64 year age range and in need of annual mammograms and clinical breast examinations. National data on Hispanic women indicate a lower incidence of breast cancer but a higher mortality rate, due to barriers to health care access, including

cultural barriers. A study of breast cancer incidence and mortality rates among Latinas in the District may be indicated.

Project WISH will continue providing breast health education, free clinical examinations, mammograms and any necessary diagnostic services to women ages 50 through 64 who meet the program requirements.

Cervical Cancer Mortality

12-2.2: Reduce cervical cancer mortality to an age-adjusted rate of no more than 0.88 per 100,000 population. **Baseline**: The age-adjusted mortality rate for cervical cancer was 4.3 per 100,000 population in the District of Columbia in 2000 (Cancer Incidence and Mortality Report for 2000).

Rationale: Cervical cancer mortality rates in the US have declined over 40 percent since the 1970s, in large part because of the widespread use of the Pap test. The Pap test has reduced death rates by identifying cancerous and pre-cancerous cervical cells. Half of all women with newly diagnosed invasive cancer have not had a Pap test and are in need of a Pap test and pelvic exam.

Project WISH provides education, free Pap tests and any necessary diagnostic services to uninsured, low income women who meet program requirements. Project WISH is developing linguistically appropriate approaches to reach women from immigrant and ethnic groups who are less likely to report ever having a Pap smear.

Colorectal Cancer Mortality ((There is no program to support this objective.)

12-3: Reduce colorectal cancer mortality to an age-adjusted rate of no more than 12.2 per 100,000 population. **Baseline**: The age-adjusted mortality rate for colorectal cancer was 17.7 per 100,000 population in 1997.

Prostate Cancer

Issues and Trends:

It appears that District of Columbia men are being screened for prostate cancer in increasing numbers. According to the results of the 2000 District of Columbia Behavioral Risk Factor Surveillance Survey 72.2% of men over 40 reported having received a PSA test, and 81.6% reported having received a Digit Rectal Examination (DRE) during the previous year. This is in comparison to 64.34% and 71.36%, respectively, in the previous survey report.

Disparities:

In the District of Columbia, the incidence and mortality rates for prostate cancer in African American men are among the highest in the nation, with an incidence rate of 240.4 cases per 100,000 persons and a mortality rate of 42.4 cases per 100,000 persons. In DC, the incidence of prostate cancer is highest in Ward 4 (278.4) and lowest in Ward 3 (187.4).The mortality rate is also highest in Ward 4 (52.8) and lowest in Ward 3 (26.0).

Opportunities:

The establishment of community-based education, and screening programs that are based on informed decision-making, and are linked to health care providers for diagnostic and treatment services, warrants serious consideration. These programs should be established in those Wards of the city that have the highest incidence and mortality rates (Wards 4,5,6,7, and 8).

Revised 2010 Objective for Prostate Cancer

Prostate Cancer Mortality

12-4: Reduce the prostate cancer mortality rate for African American men to no more than 24.4 per 100,000 population. **Baseline:** The overall mortality rate for prostate cancer in the District was 27.8 per 100,000 population in 1997. For African American men, the prostate cancer mortality rate has decreased from 32.9 in 1997 to 29.0 per 100,000 population in 2002. (Cancer Incidence and Mortality Report)

Rationale: Mortality rates are more likely to decline, if prostate screening rates for African American men significantly increase in response to the following: increased understanding of their high risk status and the importance of seeking early detection, and the removal of financial/geographic barriers to clinical services.

Comparable National 2010 Objectives

Comparable objectives from the federal *Healthy People 2010 Plan* are the following:
3-3: Breast cancer deaths
3-4: Cervical cancer deaths
3-7: Prostate cancer deaths
3-14: Statewide Cancer Registry

Focus Area 12: Cancer - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
12-1. Reduce the mortality rate for cancer of the lung and bronchus to no more than – (to be determined or TBD) per 100,000 residents. *This objective has not Been addressed.*	The age-adjusted mortality rate for cancer of the lung and bronchus was 60 per 100,000 in 2000. (DOH Cancer Incidence and Mortality Report for 2000)	Lung and bronchus cancer mortality rate has been reduced to no more than – (TBD) per 100,000 residents.
12-2.1. Reduce breast cancer mortality to an age-adjusted death rate of no more than 24.4 per 100,000 residents.	The age-adjusted breast cancer mortality rate in DC was 27.0 per 100,000 residents in 2000. (Cancer Incidence and Mortality Report)	Breast cancer mortality rate has been reduced to 24.4 per 100,000 residents.
12-2.2 Reduce cervical cancer mortality to an age-adjusted rate of no more than 0.88 per 100,000 residents.	The age-adjusted mortality rate for cervical cancer was 4.3 per 100,000 residents in the District in 2000. (Cancer Incidence and Mortality Report)	Cervical cancer mortality rate reduced to 0.88 per 100,000 residents.
12-3. Reduce colorectal cancer mortality to an age-adjusted death rate of no more than 12.2 per 100,000 residents. *This objective has not been addressed.*	The age-adjusted mortality rate for colorectal cancer was17.7 per 100,000 residents in the District in 1997.	Colorectal cancer mortality rate reduced to 12.2 per 100,000 residents.
12-4. Reduce the prostate cancer mortality among African American men to no more than 24.2 per 100,000 residents.	12-4. The overall mortality rate for prostate cancer in the District was 27.8 per 100,000 residents in 1997. For African American men the prostate cancer mortality rate was 32.9 per 100,000 in 1997. (Cancer Incidence and Mortality Report)	12-4 The prostate cancer mortality rate for African American men in the District is no more than 24.2 per 100,000 residents.

2010 GOAL: DISEASE SURVEILLANCE – CANCER REGISTRY

The District of Columbia Cancer Registry is a population-based cancer surveillance system that maintains a record of the occurrence of all malignant cancer cases among District residents. In the section on Cancer in the federal *Healthy People 2010 Plan*, cancer registries that provide accurate, complete, and timely data are cited as a critical component of the public health infrastructure in the US.

In conformity with the national *Healthy People 2010* goal for cancer registries, **the DC Cancer Surveillance System** aims to provide data to monitor efforts to reduce the number of new cancer cases, as well as the illness, disability, and death attributable to cancer.

Revised 2010 Objectives for Disease Surveillance – the DC Cancer Registry

Establishment of a Statewide. Population-based Cancer Registry

12-5.1**:** Establish a statewide population-based cancer registry that captures information on at least 95 percent of the expected number of reportable cases.
Baseline 12-5.1: As of January 2003, 3240 (100% percent) of the expected number of reportable cases had been being captured for the reference year 2000.

Rationale: Data from the DOH Cancer Registry Surveillance System are critical for the following applications: as the foundation for a District-wide comprehensive strategy to reduce cancer morbidity and mortality; as an indispensable tool for health professionals in the research and analysis of the cancer burden imposed on residents; and as the basis for monitoring and evaluation of the clinical (screening and diagnostic and treatment), epidemiological and supportive health services provided residents diagnosed with cancer.

12-5.2: Enable the DC Cancer Surveillance System to monitor trends in the incidence and death rates from cancer of selected organ sites using the District's Cancer Registry System. **Baselines** for organ sites are as follows:

12-5.2a: Crude incidence and death rates for lung and bronchus cancer cases among residents captured by the Cancer Registry in 2000 were 62.9 and 58.4 per 100,000 population, respectively.

12-5.2b: Crude incidence and death rates in breast cancer cases among residents captured in 2000 were 184.0 and 29.1 per 100,000, respectively.

12-5.2c: Crude incidence and death rates in cervical cancer cases among residents captured in 2000 were 15.5 and 4.6 per 100,000, respectively.

12-5.2d: Crude incidence and death rates in colorectal cancer cases among residents captured in 2000 were 74.6 and 29.0 per 100,000, respectively.

12-5.2e: Crude incidence and death rates in prostate cancer cases among residents captured in 2000 were 211.2 and 37.5 per 100,000, respectively.

Rationale: Monitoring trends in total cancers, and the seven leading cancer sites is required for cancer surveillance, for the following reasons: The seven sites are the ones most amenable to medical intervention and likely to have the greatest impact on cancer incidence and mortality rates; They account for nearly 66 percent of all incident cancers, and 55 percent of all cancer deaths in the District of Columbia.

12-5.3: Enable the DC Cancer Surveillance System to monitor trends in the cancer incidence and death rates of selected racial/ethnic groups using the Cancer Registry.

Rationale: Data from the DOH Cancer Registry Surveillance System is critical for the assessment and elimination of health disparities. Data addressing differences in racial and ethnic categories are indispensable in the research and analysis of the cancer burden imposed on all District residents and to devise appropriate strategies to reduce disparities in cancer morbidity and mortality noted in national trends.

Focus Area: Diabetes

Overview

Issues and Trends:

Diabetes is a serious and costly disease that is on the rise in the District of Columbia. **The Diabetes Prevention and Control Program** estimates that the prevalence of diabetes in the District was 8.3% in 2003 representing 45,000 persons with diagnosed diabetes. The Diabetes Prevention and Control Program also estimates that an additional 10,000 had undiagnosed diabetes. This represents an increase of almost 50% between 1996 and 2003 in trends.

Disparities:

From 1996 to 2003, disparities based on racial/ethnic background and on socioeconomic status (SES) were observed. Blacks and Hispanics were disproportionately affected by diabetes being four times more likely to have diabetes compared to whites. DC residents from all racial/ethnic backgrounds with low SES were more affected by diabetes than people from medium and high SES. SES is a stronger determinant of diabetes than race or ethnicity in the District of Columbia.

Opportunities:

Opportunities to address the increase of diabetes prevalence and continued poor health outcomes among various races/ethnicities and low SES residents exist. Prevention of diabetes through a reduction in the number of people becoming overweight or obese has the potential to significantly slow the increase in diabetes prevalence. Diabetes-related health complications continue to be a significant source of morbidity and monetary cost in the District of Columbia. Meeting standards for the delivery and quality of diabetes preventive health care services would significantly reduce the number of diabetes-related complications and associated costs.

Revised 2010 Objectives for Diabetes

Mortality with Diabetes as the Primary Cause among Residents, particularly African Americans

13-1: Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000 population. **Baseline**: The age-adjusted mortality rate due to diabetes as the primary cause of death was 37.5 per 100,000 population in the District in 2001.

13-2: Reduce the mortality rate for diabetes as the primary cause of death among African American residents of the District to 30.9 per 100,000 population. **Baseline:** The mortality rate for diabetes as the primary cause among African American residents was 55.05 (crude rate) per 100,000 population in 2001.

Diabetic Residents Having an Annual A1c Measurement

13-3: Increase to 80 percent the proportion of District residents with diabetes who report having a yearly hemoglobin A1c measurement. **Baseline:** 62.5 percent of diabetic residents in the District reported having a hemoglobin A1c measurement yearly in 2001, according to the Behavioral Risk Factor Surveillance System or BRFSS.

Rationale: Nearly 30 percent of District residents did not have a yearly A1c measurement in 1997. This represents a substantial proportion of the population that did not receive a basic and necessary procedure.

13-4: Deleted

Diabetic Residents Having an Annual Dilated Eye Examination

13-5: Increase to 85 percent the proportion of District residents with diabetes who report having a dilated eye examination within the past year. **Baseline:** 75.6 percent of diabetic residents in the District so reported in the 2001 BRFSS.

Rationale: In 1997, there were 38 new cases of blindness due to diabetes. Diabetes related eye disease is preventable; and complications from diabetic eye disease can be minimized, if the appropriate treatment is initiated early on in the disease process.

Diabetic Residents Having Their Feet Checked by a Health Professional in the Past Year

13-6: Increase to 75 percent the proportion of District residents with diabetes who report having their feet checked for sores or irritations by a health care professional within the past year. **Baseline:** 72.5 percent of diabetic residents in the District so reported in the 2001 BRFSS.

Rationale: In 1997, 43 percent of all District residents with diabetes did not have a foot examination by a health professional in the past year. Additionally, there were 177 lower extremity amputations performed due to diabetes.

Diabetic Residents Having an Oral Health Examination within the Past Year

13-7: Increase the proportion of District residents with diabetes who report having an oral health examination within the previous 12 months to 30 percent or by 50 percent, whichever is greater. **Baseline:** 57.0 percent of diabetic residents in the District so reported in the 1999 BRFSS.

Diabetic Residents Having at least one Encounter with Health Care Provider Focused on Self-management in Past Year

13-8: Increase by 50 percent the proportion of District residents with diabetes who report participating in the past 12 months in at least 1 health care provider encounter focusing on self-management strategies. **Baseline**: 53.2 percent of diabetic residents in the District so reported in the 2001 BRFSS.

Diabetic Residents Reporting Daily Self-examination of Feet

13-9: Increase by 50 percent the proportion of District residents with diabetes who report self-examination of their feet at least once daily. **Baseline:** 64.0 percent of diabetic residents in the District so reported in the 2001 BRFSS.

Diabetic Residents Reporting Receiving at least one Encounter with Health Care Provider Devoted to Dietary Counseling

13-10: Increase by 50 percent the proportion of District residents with diabetes who report at least one encounter with a health care provider devoted to dietary counseling (consisting of eating more fruit and vegetables and less high fat/cholesterol foods). **Baseline:** 54.9 percent of diabetic residents in the District so reported in the 2001 BRFSS.

13-11: Deleted

13-12: Decrease the percentage of DC residents who have an A1c measurement in the past 12 months with a value of 9 percent or above. **Baseline**: To be established.

Comparable National 2010 Objectives

Comparable objectives from the federal *Healthy People 2010 Plan* are the following:
5-5: Diabetes deaths and 5-6: Diabetes-related deaths
5-12: Yearly glycosylated hemoglobin measurement
5-13: Annual dilated eye examinations
5-14: Annual foot examinations
5-15: Self-blood-glucose monitoring

Focus Area 13: Diabetes - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
13-1. Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000 residents.	The age-adjusted mortality rate due to diabetes as the primary cause of death was 37.5 per 100,000 residents in 2001.	The age-adjusted mortality rate due to diabetes as the primary cause of death is 22.9 per 100,000 residents.

Objectives	Baseline	2010 Goal
13-2. Reduce the mortality rate for diabetes as the primary cause of death among African American residents of the District to 30.9 per 100,000 population.	The mortality rate with diabetes as the primary cause among African American residents in the District was 55.05 (crude rate) per 100,000 in 2001.	The mortality rate with diabetes as the primary cause of death among African Americans in the District is 30.9 per 100,000 population.
13-3. Increase to 80 percent the proportion of District residents with diabetes who report having a yearly hemoglobin A lc measurement.	62.5 percent of diabetic residents in the District reported having hemoglobin A lc measurement yearly in 2001 according to the Behavioral Risk Factor Surveillance Survey (BRFSS).	80 percent of residents report obtaining a yearly hemoglobin A lc measurement.
13-4 Deleted		
13-5. Increase to 85 percent the proportion of District residents with diabetes who report having a dilated eye exam within the past year.	75.6 percent of diabetic residents in the District so reported in the 2001 BRFSS.	85 percent of diabetic residents in the District will obtain a dilated eye exam in this year.
13-6. Increase to 75 percent the proportion of District residents with diabetes who report having their feet checked for sores or irritations by a health care professional within the past year.	72.5 percent of diabetic residents in the District so reported in the 2001 BRFSS.	75 percent of District residents with diabetes report having their feet checked for sores or irritations by a health care professional in this year.
13-7. Increase the proportion of District residents with diabetes who report having an oral health exam within the previous 12 months to 30 percent or by 50 percent, whichever is greater.	57.0 percent of diabetic residents in the District so reported in the 1999 BRFSS.	30 percent (or an increase by 50 percent) of District residents with diabetes report having an oral health exam within the previous 12 months.
13-8.Increase by 50 percent the proportion of District residents with diabetes who report participating within the previous 12 months in at least 1 health care provider encounter focusing on self-management strategies.	53.2 percent of diabetic residents in the District so reported in the 2001 BRFSS.	100 percent of residents with diabetes report participating within the past 12 months in at least 1 health care provider encounter focusing on self-management strategies.

Objectives	Baseline	2010 Goal
13-9. Increase by 50 percent the proportion of District residents with diabetes who report self-examination of their feet at least once daily.	64.0 percent of diabetic residents in the District so reported in the 2001 BRFSS.	70 percent of District residents with diabetes report self-examination of their feet at least once daily.
13-10. Increase by 50 percent the proportion of District residents with diabetes who report at least one encounter with a health care provider devoted to dietary counseling (consisting of eating *more* fruit and vegetables and *less* high fat/cholesterol foods).	54.9 percent of diabetic residents in the District so reported in the 2001 BRFSS.	90 percent of District residents with diabetes report at least one encounter with a health care provider devoted to dietary counseling.
13-11. Deleted		
13-12. Decrease the percentage of DC residents who have an A1c measurement in the past 12 months with a value of 9 percent or above. Interim target: By September of 2006, develop a white paper which describes the rational, system capacity needs, and model programs from decreasing the percent of residents with an A1c measurement below 9 percent.	Baseline to be established.	The percentage of DC residents having an A1c measurement in the past 12 months with a value of 9 percent or above has been decreased.

Focus Area: Disabilities

Overview

Issues and Trends:

Estimates of the number of persons with disabilities vary according to the source. The 2000 US Census indicates that 21.9 percent of persons age five and over have some type of disability, as compared to 19.3 percent of the US population as a whole. The proportion ranged from 10.0 percent for 5 to 20 years old, to 21.9 percent for persons 21 to 64 years old, and to 42.5 percent for persons 65 years old and above. The American Community Survey Profile for 2003 reveals that among people at least five years old in 2003, 14 percent reported a disability. The likelihood of having a disability varied by age from 8 percent of persons 5 to 20 years of age, to 11 percent of persons 21 to 64 years of age, and to 36 percent of those 65 years old and above. In contrast, 16.2 percent of respondents to the 2003 District of Columbia Behavioral Risk Factor Surveillance System (BRFSS) reported a limitation in activities due to physical, mental or emotional problems.

Disparities:

The results of the BRFSS from 2001-2003 point to the disparities in the leading health indicators of physical activity and overweight and obesity between persons with and those without activity limitations. When asked about their perception of their own health status, persons with activity limitations were four times more likely to describe their health as fair or poor compared to persons with no activity limitations. Persons with activity limitations were also more likely to have a body mass index in the overweight or obese categories compared to those reporting no activity limitations. In the category of physical activity, persons with activity limitations were at least 10 percent less likely to participate in any physical activity or exercise.

Opportunities

The disparity in health status indicators for persons with disabilities presents several opportunities for focused health promotion and intervention activities. In cooperation with their family members, advocacy groups and local and federal government agencies, persons with disabilities may strive to achieve improved health outcomes utilizing these objectives as guidelines.

Revised 2010 Objectives for Disabilities

Hospital Reporting to DOH of Data on Children Born at risk of Developmental Delay or Disability

14-1: Ensure that 100 percent of hospitals in the District of Columbia report data on children born at risk for developmental delays or disability to the DOH agencies charged with collecting such information. **Baseline**: 33 percent of hospitals

provided DOH agencies with data on children born at risk of developmental delay or disability in 2001.

Use of a Standardized Set of Parameter in Core Surveillance Instruments for the Collection of Data on Persons with Disabilities

14-2: Ensure that 100 percent of the relevant DOH programs include a standardized set of parameters in their core surveillance instruments that include information on persons with disabilities. **Baseline**: 20 percent of relevant DOH programs collect data on persons with disabilities.

Participation of Persons with Disabilities in Physical Activities or Exercise

14-3: Increase to 80 percent the proportion of residents with disabilities participating in physical activity or exercise. **Baseline:** 44.8 percent of residents with health problems requiring the use of special equipment* reported participating in physical activities or exercise in 2001 (BRFSS). 63.6 percent of residents with limited activities due to physical, mental or emotional problems reported participating in physical activities or exercise in 2001 (BRFSS).

*BRFSS question: Do you now have any health problem that requires you to use special equipment, such as a cane, wheelchair, special bed or special telephone.

Decrease Proportion of Persons with Disabilities who are Overweight or Obese

14-4: Decrease to 50 percent the proportion of residents with disabilities who are overweight or obese. **Baseline**: 67.7 percent of residents with health problems requiring the use of special equipment were overweight or obese in 2001 (BRFSS). 31.3 percent of residents with limited activities due to physical, mental or emotional problems were overweight or obese in 2001 (BRFSS).

14-5: Increase to 75 percent the proportion of residents with disabilities who are satisfied with their general health. **Baseline:** 48.3 percent of residents with health problems requiring the use of special equipment reported their general health as excellent to good in 2001 (BRFSS). 61.8 percent of residents limited in activities due to physical, mental or emotional problems reported their general health as excellent or good in 2001 (BRFSS).

14-6: Increase to 80 percent the proportion of residents with disabilities who have a nutritious diet. **Baseline**: 31.9 percent of residents with health problems requiring the use of special equipment reported eating fruits and vegetables five or more times per day in 2002 (BRFSS). 31.3 percent residents with limited activities due to physical, mental or emotional problems reported eating fruits and vegetables five or more times per day in 2002 (BRFSS).

Comparable National 2010 Objectives

Comparable federal *Healthy People 2010* objectives are the following:
6-1: Standard definition of people with disabilities in data sets
6-10: Accessibility of health and wellness programs

Focus Area 14: Disabilities - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
14-1 Ensure that 100 percent of hospitals in the District of Columbia report data on children born at risk for developmental delay or disability to the Department of Health (DOH) agencies charged with collecting such information.	33 percent of hospitals provided DOH agencies with data on children born at risk for developmental delay or disability in 2001.	100 percent of hospitals which provide child birth services in the District will report to the relevant DOH agencies data on children born at risk for developmental delay or disability.
14-2 Ensure that 100 percent of the relevant DOH programs have a standardized set of parameters in their core surveillance instruments that include information on persons with disabilities.	20 percent of relevant DOH Health programs collected data on disability status in 2001.	100 percent of the relevant DOH programs have a standardized set of parameters in their core surveillance instrument that includes information on persons with disabilities.
14-3 Increase to 80 percent the proportion of residents with disabilities participating in physical activity or exercise**.**	44.8 percent of residents with health problems requiring the use of special equipment* reported participating in physical activities or exercise in 2001 Behavioral Risk Factor Surveillance System (BRFSS). 63.6 percent of residents with limited activities due to physical, mental, or emotional problems reported participating in physical activities or exercise in 2001 (BRFSS).	80 percent of residents with disabilities participate in physical activity or exercise.

Objective	Baseline	2010 Goal
14-4 Decrease to 50 percent the proportion of District residents with disabilities who are overweight or obese.	67.7 percent of District residents that have health problems that require them to use special equipment* were overweight or obese in 2001 (BRFSS). 31.3 percent of District residents who are limited in activities due to physical, mental, or emotional problems were overweight or obese in 2001 (BRFSS).	50 percent of District residents with disabilities are overweight or obese.
14-5 Increase to 75 percent the proportion of residents with disabilities who are satisfied with their general health.	48.3 percent of residents with health problems requiring the use of special equipment* reported their general health as excellent to good in 2001 (BRFSS). 61.8 percent of residents limited in activities due to physical, mental, or emotional problems reported their general health as excellent or good in 2001 (BRFSS).	75 percent of District residents with disabilities are satisfied with their general health.
14-6 Increase to 80 percent the proportion of residents with disabilities who have a nutritious diet.	31.9 percent of residents with health problems requiring the use of special equipment* reported eating fruits and vegetables five or more times per day in 2002 (BRFSS). 31.3 percent of residents limited in activities due to physical, mental, or emotional problems reported eating fruits and vegetables five or more times per day in 2002 (BRFSS).	80 percent of residents with disabilities have a nutritious diet.

BRFSS question: Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?

Focus Area: Cardiovascular Diseases (Heart Disease and Stroke)

Overview

Issues and Trends:

The District of Columbia bears a heavy burden. According to data from the District of Columbia Hospital Association, from 1995 through 1998, Cardiovascular Disease (CVD) was the leading cause for hospitalization in the city. The disease causes more than one third of the deaths in the District – one death every 30 minutes.

Disparities:

District of Columbia data from the Behavioral Risk Factor Surveillance System (BRFSS) has highlighted disparities in CVD between African Americans and other ethnic and racial groups – for example, CVD is 3.5 times as likely to strike African Americans as whites (or other racial/ethnic groups). This disparity is seen in rates for deaths, hospitalizations, and modifiable risk factors such as obesity, smoking, and physical inactivity. African Americans also have relatively high rates of diabetes, overweight, transient ischemic attacks (strokes), sickle cell anemia, inadequate nutrition, and hypertension – all of which are risk factors for CVD. Furthermore, most hospitalizations among African Americans are because of CVD.

Opportunities:

Although many District residents are affected by CVD, many of its risk factors can be prevented. Primary prevention (reduction in the incidence of disease) directed at the root causes of CVD – behaviors, environments, and policies that hinder early detection and treatment of CVD is effective in altering the disease effects. Secondary or tertiary prevention (reduction of the complications of disease and the improvement in the patient's level of function through palliative treatment and rehabilitation therapy) are not as effective. **The Cardiovascular Health Program of the DC Department of Health** was developed to promote cardiovascular health in the city. Strategies of the Program include raising awareness of CVD, increasing services, and creating policies supportive of health.

Revised 2010 Objectives for Cardiovascular Disease

Deaths from Heart Disease

15-1: Reduce deaths from heart disease to no more than 230.2 per 100,000 population. **Baseline**: The age-adjusted mortality rate for heart disease was 273.7 per 100,000 population in 2000.

Rationale: Heart disease is the leading cause of death in the District of Columbia. Risk factors for cardiovascular disease (heart disease and stroke) – such as high blood pressure, elevated cholesterol, and overweight – are common among District residents. Risk reduction strategies need to be taught and monitored.

Prevalence of High Blood Pressure

15-2: Reduce the proportion of adults with high blood pressure to no more than 10 percent. **Baseline**: 19.3 percent of adult residents reported being diagnosed with high blood pressure in 1997, according to the National Health and Nutrition Examination Survey (NHANES).

Residents with High Blood Pressure that is Under Control

15-3: Increase to at least 50 percent the proportion of adult residents with high blood pressure whose pressure is under control. **Baseline**: Nationally 18 percent of persons 18 years and older with high blood pressure had it under control (19 percent of African Americans) in 1988-1994 (NHANES).

Residents Attempting to Control Their High Blood Pressure

15-4: Increase to at least 95 percent the proportion of residents with high blood pressure who are taking action to help control their blood pressure. **Baseline**: Nationally 72 percent of people with high blood pressure ages 18 and above took measures to control their blood pressure, such as medication and diet modification in 1998. (National Health Interview Survey or NHIS). District baseline to be determined.

Residents Having Blood Pressure Measurements in Past Two Years

15-5: Increase to 100 percent the proportion of adults who have had their blood pressure measured within the past two years and can state whether their blood pressure was normal or high. **Baseline**: 97 percent of District residents reported having had their blood pressure checked within the past two years in 1994 (BRFSS).

Reduction in Mean Total Blood Cholesterol Levels

15-6: Reduce the mean total blood cholesterol levels among District residents to no more than 193 mg/dL. **Baseline:** Nationally, adult Americans ages 20 and above had blood cholesterol levels of 206 mg/dL in 1988-1994 (NHANES). District baseline to be established.

Reduction in Prevalence of High Blood Cholesterol Levels

15-7: Reduce the prevalence of blood cholesterol levels of 240 mg/dL in adult residents to no more than 13 percent. **Baseline**: Nationally 21 percent of adult Americans ages 20 and above had blood cholesterol levels of 240 mg/dL or greater (1988-1994 (NHANES). District baseline to be added.

Reduction in Deaths from Stroke

15-8: Reduce the mortality rate from stroke to no more than 33.2 per 100,000 population. **Baseline**: The age-adjusted mortality rate for stroke in the District was 39.5 per 100,000 population in 2000 (DOH CVD Program).

Rationale: Cerebrovascular disease (stroke) was the fourth leading cause of death in the District of Columbia in 2000. Risk factors for stroke such as high blood pressure, elevated cholesterol, and overweight are common among residents.

Comparable National 2010 Objectives

Comparable federal Healthy People 2010 objectives are the following:
12-1: Coronary heart disease (CHD) deaths
12-7: Stroke deaths
12-9: High blood pressure
12-10: High blood pressure control
12-11: Action to control high blood pressure
12-12: Blood pressure monitoring
12-13: Mean total blood cholesterol level
12-14: High blood cholesterol levels
12-15: Blood cholesterol screening

Focus Area 15: Cardiovascular Disease - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
15-1. Reduce deaths from heart disease to no more than 230.2 per 100,000 people.	The age-adjusted mortality rate from heart disease was 273.7 per 100,000 population in 2000. (Source: DOH CVD Program epidemiologist)	Deaths from heart disease have been reduced to no more than 230.2 per 100,000 people.

Objective	Baseline	2010 Goal
15-2. Reduce the proportion of adult residents with high blood pressure to no more than 10 percent.	19.3 percent of adult residents reported being diagnosed with high blood pressure in 1997. (CDC/NCHS, National Health and Nutrition Examination Survey or NHANES)	No more than 10 percent of adult residents has high blood pressure.
15-3. Increase to at least 50 percent the proportion of adult residents with high blood pressure whose pressure is under control.	Nationally 18 percent of persons 18 years and older with high blood pressure had it under control (19 percent of African Americans) in 1988-1994 (NHANES).	At least 50 percent of adult residents with high blood pressure have it under control.
15-4.Increase to at least 95 percent the proportion of people with high blood pressure who are taking action to help control their blood pressure.	Nationally, 72 percent of people with high blood pressure ages 18 and above took measures to control their blood pressure, such as medication and diet modification in 1998. (National Health Interview Survey or NHIS) District baseline to be established.	95 percent of District residents with high blood pressure take actions to help control it.
15-5. Increase to 100 percent the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high.	97 percent of District residents reported having had their blood pressure checked within the past two years in 1994 (BRFSS).	100 percent of adults in the District have had their blood pressure checked within the past two years.
15-6.Reduce the mean total blood cholesterol levels among District adults to no more than 193 mg/dL.	Nationally, adult Americans ages 20 and above had blood cholesterol levels of 206 mg/dL in 1988-1994 (NHANES). District baseline to be established.	Residents have mean total cholesterol levels of no more than 193 mg/dL.
15-7. Reduce the prevalence of blood cholesterol levels of 240 mg/dL to no more than 13 percent.	Nationally, 21 percent of adult Americans ages 20 and above had blood cholesterol levels of 240 mg/dL or greater (1988-1994 NHANES).	Prevalence of blood cholesterol levels of 240 mg/dL or greater among adults is no more than 13 percent.

Objective	Baseline	2010 Goal
15-8. Reduce the mortality rate from stroke to no more than 33.2 per 100,0000 residents.	The age-adjusted mortality rate for stroke in the District was 39.5 per 100,000 residents in 2000 (DOH CVD Program).	The mortality rate from stroke is no more than 33.2 per 100,000 residents.

Focus Area: HIV/AIDS

Responsible sexual behavior is A leading health indicator.

Overview

Issues and Trends:

- The percent average for individuals who tested HIV positive and were also diagnosed with STD was 20 percent in 1996-1999, and 19 percent in 200-2003.

- The percentage (37.8 percent) of TB cases reported among persons between 25 and 44 years of age is alarming, because 6.4 percent of the 82 reported TB cases also were HIV positive and were between the ages of 25 and 44 years of age.

- The percent average for individuals who tested HIV positive and reported having sex with men (MSM) was 30 percent in 1996-1999 and 25 percent in 2000-2003.

- The percent average for individuals who tested HIV positive and who had sex with men, and also injected drugs (MSM/DU) was 2 percent in 1996-1999 and 2 percent in 2000-2003.

- The percent average for all individuals who tested HIV positive and reported injecting drugs (IDUs) was 13 percent in 1996-1999 and 13 percent in 2000-2003.

- The percent average for individuals who tested HIV positive and reported heterosexual contact was 15 percent in 1996-1999 and 12 percent in 2000-2003.

Disparities:

AIDS cases attributed to heterosexual contact make up about 22 percent of all AIDS cases in 1996-2003 and about 20 percent of living AIDS cases. Men who have sex with men (MSM), make up the largest group of all AIDS cases (32 percent) and living AIDS cases (37 percent) in 1996-2003. Injecting drug users comprise the next largest group of all AIDS cases (25 percent) in 1996-2003, and about 24 percent of living AIDS cases.

Opportunities:

The recent requirement of HIV case reporting by laboratories has caused the number of newly discovered AIDS cases to significantly rise.

Revised 2010 Objectives for HIV/AIDS

Identification of HIV+ Individuals

16-1: Increase by 5 percent annually the proportion of HIV+ individuals identified through HIV counseling and testing (by programs funded through the HIV/AIDS Administration (HAA) and the Centers for Disease Control and Prevention (CDC). **Baseline**: 209 individuals were identified as HIV+ through counseling and testing services in FY 2003 (Counseling and Testing database)

Rationale: The timely access to HIV antibody testing and counseling, especially in highly affected communities, will increase awareness and knowledge of preventive and protective behaviors that reduce the risk of exposure to infection.

Increase the Number of Newly Reported AIDS Cases Resulting from Active Case Findings

16-2: Increase by 5 percent annually the number of newly reported AIDS cases as a result of active case findings. **Baseline:** 1,160 newly reported AIDS cases were recorded as a result of active case findings in FY 2003 (AIDS Surveillance database).

Increase the Number of HIV+ Individuals Receiving Housing Assistance Services

16-3: Increase by 10 percent annually the number of HIV+ individuals who receive Housing Assistance services (by programs funded through the HIV/AIDS Administration and HOPWA). **Baseline:** 400 housing slots were occupied in FY 2003 (Monthly reports).

Rationale: The significant numbers of persons with HIV/AIDS who are homeless or at risk of homelessness in the District of Columbia pose a threat to continuous provision of care and improvement of quality of life.

Increase Enrollment of HIV+ Individuals in ADAP

16-4: Increase by 2.5 percent annually the number of HIV+ individuals who enroll in AIDS Drug Assisted Program (ADAP). **Baseline**: 646 HIV+ individuals were newly enrolled in ADAP in FY 2003 (ADAP Enrollment database).

Comparable National Objectives

Comparable federal Healthy People 2010 objectives are the following:
13-1: New AIDS cases
13-5: New HIV cases
13-7: Knowledge of serostatus

Focus Area 16: HIV/AIDS – Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
16-1. Increase by 5 percent annually the proportion of HIV+ individuals identified through HIV counseling and testing (by programs funded through the HIV/AIDS Administration and the Centers for Disease Prevention and Control (CDC)).	209 individuals were identified as HIV+ through counseling and testing services as FY 2003 (Counseling and Testing database).	There is a 5 percent annual increase in the number of HIV+ individuals identified through HIV counseling and testing (by programs funded through the HIV/AIDS Administration and the CDC).
16-2. Increase by 5 percent annually the number of newly reported AIDS cases as a result of active case findings.	1,160 newly reported AIDS cases were recorded as a result of active case findings in FY 2003 (AIDS Surveillance database).	There is a 5 percent annual increase in the number of newly reported AIDS cases as a result of active case findings.
16-3. Increase by 10 percent annually the number of HIV+ individuals who receive Housing Assistance services (by programs funded through the HIV/AIDS Administration and HOPWA *)*	400 housing slots were occupied in FY 2003 (Monthly reports)	There is a 10 percent annual increase in the number of HIV+ individuals receiving housing assistance services (by programs funded through the HIV/AIDS Administration and the HOPWA).
16-3.1. Dropped		
16-4. Increase by 2.5 percent annually the number of HIV+ individuals who enroll in AIDS Drug Assisted Program (ADAP).	646 HIV+ individuals were newly enrolled in ADAP in FY 2003 (ADAP Enrollment database).	There is a 2.5 percent annual increase in the number of HIV+ individuals newly enrolled in ADAP.

Focus Area: Immunization

Overview

Immunization is a leading health indicator.

Issues and Trends:

Vaccines can prevent debilitating illness and, death from various infectious diseases. Childhood vaccines help to eliminate the illness of polio, measles, and rubella. The organisms that cause these diseases have not disappeared. They have receded, but will quickly reemerge if vaccine coverage levels drop. Vaccines also protect society. When the vaccine levels in a community are high, the few that are not vaccinated are often indirectly protected because of group immunity.

Vaccines also provide great cost benefits. The childhood vaccines DTaP, MMR, and Hib result in a noticeable direct medical savings for each dollar spent to vaccinate children against these diseases. The District of Columbia has 90% or greater coverage level for many of these vaccines among the 0-4 yr old population.

During the late 1990's, vaccination rates for children 19-35 months had reached record high levels. Since 1979, the District of Columbia has required vaccination for children attending school and daycare. Currently the District is requiring children attending school and daycare to be fully immunized.

Disparities:

Historically, vaccination rates for children in certain racial and ethnic groups have been low. Vaccination rates among preschool and school age children in these racial and ethnic groups have begun to increase at a rapid rate, thus narrowing the gap.

Vaccination rates for influenza and pneumococcal infections among people aged 65 and older have improved for African Americans and Hispanics. The level among these groups, however, remains significantly below that of the general population.

Opportunities:

The 5 major strategies to protect people from vaccine preventable diseases (VPD'S) are

as follows:

- Improving vaccination delivery services;
- Minimizing financial burdens for the needy;
- Increasing community partnerships, education, and participation;
- Increased monitoring of disease and vaccination coverage; and
- Development of new or improved vaccines.

The above mentioned strategies include many interventions for children, such as entry requirements for school and the promotion of the **Vaccines for Children Program.** Conducting coverage level assessment at clinics and provider offices is also important.

The results of these assessments can be discussed with the providers, in order to develop plans to increase their coverage levels. Populations at risk can be served by other programs such as Women, Infant, and Children (WIC). **The Immunization Registry** stores immunization records and serves as a valuable tool for assisting parents and providers identify immunization needs for individual children.

Revised DC Healthy People 2010 Objectives for Immunization

17-1: Dropped
17-2: Dropped

Immunization Coverage for Children in Licensed Childcare Facilities, Heart Start, and Prekindergarten Classes

17-3: Maintain immunization coverage at 95 percent for children in licensed childcare facilities, Head Start, and prekindergarten classes. **Baseline**: Coverage levels for licensed childcare facilities in 2001 were 4 DtaP 95%, 3+ Polio 97%, 1+ MMR 97%, 3+ Hib 95%, and 1 Varicella/history 97% according to survey data. Head Start centers in 2001 were 4 DtaP 91%, 3+ Polio 95%, 1+ MMR 95%, 3+ Hib 91%, and 1 Varicella/history 95% according to survey data. PreK/K/1 grade students in 2001 were 4 DtaP 92%, 3+Polio 94%, 1+ MMR 98%, Hib not age appropriate, and 1 Varicella/history 91% according to survey data.

17-4: Dropped
17-5: Dropped
17-6: Dropped

17-7: Increase to 100 percent (minus any deaths) the proportion of each new birth cohort enrolled in the Central Immunization Registry. **Baseline:** This project began in the year 2001. Baseline data indicate that 76 percent (5,683 of 7,513 births, based on 1999 births to District women) of the cohort was enrolled in the Central Immunization Registry by the end of 2001.

Adult Immunization Rates for Influenza and Pneumoccal Vaccine Coverage

17-8 and 17-9 were revised and combined.

17-8: Increase to 90 percent the number of non-institutionalized adults ages 65 years and older immunized against influenza; and increase to 60 percent the number of non-institutionalized adults ages 65 years and older immunized against pneumococcal disease. **Baseline:** BRFSS coverage level data from 1999 indicate that 54 percent of non-institutionalized adults 65 and older were immunized with influenza vaccine and 32 percent of non-institutionalized adults 65 and older were immunized with pneumococcal vaccine. BRFSS 2004 data indicate that 54.8 percent of non-institutionalized adults 65 and older received an influenza vaccination; 51.3 percent of non-institutionalized adults 65 and

older received a pneumococcal vaccination.

Comparable National 2010 Objectives

Comparable national objectives from the federal *Healthy People 2010 Plan include the following:*
14-1: Vaccine-preventable diseases

Focus Area 17: Immunization - Revised 2010 Objectives, Baselines and Goals

Objective	Baseline	2010 Goal
17-1. Dropped		
17-2. Dropped		
17-3. Maintain immunization coverage at 95 percent for children in licensed childcare facilities, Head Start, and prekindergarten classes.	Coverage levels for licensed childcare facilities in 2001 were 4 DtaP 95%, 3 + Polio 97%t, 1 + MMR 97%, 3+ Hib 95%, and 1 Varicella/ history 97% according to survey data. Coverage levels for Head Start centers in 2001 were 4 DtaP 91%, 3 + Polio 95%, 1 + MMR 95%, 3+ Hib 91% and 1 Varicella/history 95% according to survey data. Coverage levels for PreK/K/1 grade students in 2001 were 4 DtaP 92%, 3+ Polio 94%, 1+ MMR 98%, Hib not age appropriate, and 1 Varicella/history 91% according to survey data.	The immunization coverage rate of 95 percent for children in licensed childcare facilities, Head Start, and prekindergarten has been maintained in the District.
17-4. Dropped		
17-5. Dropped		
17-6. Dropped		
17-7. Increase to 100 percent (minus any deaths) the proportion of each new birth cohort enrolled in the Central Immunization Registry.	This project began in the year 2001. Baseline data indicate that 76 percent (5,683 of 7,513 births, based on 1999 births to District women) of the cohort was enrolled in the Central Immunization Registry by the end of 2001.	100 percent of each new birth cohort will have been enrolled in the Central Immunization Registry.

Objective	Baseline	2010 Goal
17-8 and 17-9 were revised and combined.		
17-8. Increase to 90 percent the number of non-institutionalized adults ages 65 years and older immunized against influenza; and increase to 60 percent the number of non-institutionalized adults ages 65 years and older immunized against pneumococcal disease.	BRFSS coverage level data from 1999 indicated that 54 percent of non-institutionalized adults 65 years and older were immunized with influenza vaccine and 32 percent of non-institutionalized adults 65 and older were immunized with pneumococcal vaccine. The 2004 BRFSS data indicate that 54.8% of non-institutionalized adults 65 and older received an influenza vaccination. 51.3% of non-institutionalized adults 65 and older received a pneumococcal vaccination.	The immunization rate of 90 percent for non-institutionalized adults 65 years and older will have been increased to 90 percent for influenza and to 60 percent for pneumococcal disease; and the increase will have been maintained in the District.

Focus Area: Mental Health *Mental health is a leading health indicator.*

Overview

Issues and Trends:

The District of Columbia Department of Mental Health (DMH) is undergoing a major system reform process. Its evolution has involved entering and existing Receivership, implementing the Final Court-Ordered Plan (new system organization, funding mechanism, service delivery model, range of services for children/youth and adults, consumer protections, and building a new Saint Elizabeths Hospital). The DMH is now in a Court Monitoring phase with the establishment of Exit Criteria including performance targets to vacate the longstanding Dixon Court Order. In order to be compliant with court mandates DMH must achieve: 1) demonstrated implementation of functional consumer satisfaction methods, 2) demonstrated use of consumer functioning review methods as part of the quality improvement system for community services, 3) demonstrated planning for and delivery of effective and sufficient services, and 4) demonstrated system performance.

The Dixon performance targets address service and system issues. These include: 1) establishment of penetration rates for adults and children, 2) provision of housing, supported employment, and assertive community treatment (ACT) for adults with serious mental illness (SMI), 3) provision on newer generation antipsychotic medications for adults with schizophrenia, 4) provision of services to adults who are chronically homeless, 5) provision of services to children/youth with serious emotional disturbances (SED) in natural settings, 6) support for children/youth to live in their own home or surrogate home, 7) provision of services to children/youth who are homeless, 8) demonstration of continuity of care upon discharge from inpatient facilities (children/youth and adults), 9) increased percentage of total resources directed toward community-based services, and 10) maximization of use of Medicaid funding to support community-based services.

The DMH system change initiatives are also consistent with the recommendations in the President's New Freedom Commission on Mental Health Report. These include the following recommendations: 2.1- develop an individualized plan of care for every adult with a SMI and child with a SED, 2.2- involve consumers and family members fully in orienting the mental health system toward recovery, 2.5- protect and enhance the rights of people with mental illness, 3.1- improve access to care that is culturally competent, 4.2-improve and expand school mental health programs, 4.3- screen for co-occurring mental and substance use disorders and link with integrated treatment strategies, and 5.2- advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

Disparities:

As a requirement of the Court-ordered Dixon Exit Criteria, the Court Monitor will conduct annual reviews of community services for adults and children/youth. This process provides information on consumers' perceptions of services provided and system performance.

The findings for the Annual Adult Community Services Review (CSR) in FY 2004 (Year 2), indicate that the overall status of the consumers was at a 54 percent acceptable level, individual scores showed satisfaction with services and safety receiving the highest scores (77 percent and 78 percent, respectively), while scores in work and recovery activities were at a 35 percent acceptable level.

The measures of how the system is performing also look at multiple domains (i.e., treatment and service implementation, practical support, service coordination and recovery plan adjustments). The DMH scored at a 39 percent acceptable level on these measures. The goal is to achieve an 80 percent level of performance.

The Year 2 data, as measured by the Child/Youth CSR, indicate that the aggregate child/youth measure was 74 percent favorable. The individual scales showed that 92 percent of children and families were in the acceptable range in terms of satisfaction with services. Although encouraging, this is in contrast to other scales (i.e., 54 percent of cases were acceptable in terms of academic status and only 48 percent in terms of responsible social behavior). The system performance measures include and quantify issues related to service coordination, availability of unique resources for each child/family member, treatment implementation, etc. For this review, the aggregate measure for systems performance was 43 percent favorable. The goal is to achieve an 80 percent favorable rating. The Year 2 data also support the continued fact that children/youth who are lower functioning are less likely to receive adequate systems support than those who are higher functioning.

Opportunities:

The DMH will continue the system restructuring activities that are ongoing. Additionally, the Department will address the system challenges that have been discovered.

The Annual Adult and Child/Youth CSR have been a major source for illuminating some of the service and system gaps. The primary conclusion from Year 2 of the CSR process is that "clinical/services staff have a very inconsistent understanding of a systems of care model." In order to ensure that workers engage in more appropriate practice activities, there needs to be "more coaching, mentoring and training of practitioners." The DMH leadership supports these conclusions and is working to address these issues.

The DMH child/youth service system is still in a developmental stage. There remains considerable work in order to create a consistent understanding and practice of resiliency concepts, child care team formation, and attention to educational needs. The DMH is actively working to address consistency of practice, system performance, family, and interagency collaboration issues.

Revised 2010 Objectives for Mental Health

Prevention-oriented Services for Children and Youth

18-1.1: Expand the prevention-oriented services for children (ages 0-2) in the Parent Infant Development Program in accordance with the MOU with the Healthy Start Program. **Baseline:** In FY 2003 (Year 1), the target was 50 mothers and children. In FY 2004 (Year 2), the target was 120, and then reduced to 80. In FY 2005 (year 3), the target remained at 80.

Rationale: DMH has a MOU with the Healthy Start Program to provide mental health services to mothers (who reside in Wards 7 and 8 and who fail the depression screening) with their babies up to age 2. Two DMH social workers provide services.

18-1.2: Expand the prevention-oriented services for children (ages 3-5) in the Therapeutic Nursery, based on increased capacity. **Baseline:** Currently (in 2005) 14 children are being served.

Rationale: DMH currently has the capacity to serve 20 children at one site (10 in each classroom). The current capacity is 20, which would have to be increased in order to expand services.

18-1.3: Expand the prevention-oriented services for children and adolescents (ages 5-18) in community programs by 10 percent annually. **Baseline**: In FY 2004, approximately 4,060 children were enrolled in the MHRS program, of this number, 2,258 were ages 0-12 and 1,802 were ages 13-18.

Rationale: DMH is implementing the mental health rehabilitation services (MHRS) program and certifies community-based providers for services to children/youth and adults that meet these standards.

18-1.4: Expand the prevention-oriented services for children in DC Charter and Public Schools. **Baseline:** In FY 2002, the SMHP provided mental health services to 1,722 children/youth.

Rationale: The DMH School Mental Health Program (SMHP) provides prevention, early intervention, and treatment services to students in the regular

education program. This includes 11 Charter and 20 DC Public Schools (of which there are 6 Transformation Schools).

Services for Adults who are Homeless with Serious Mental Illness

18-2: Increase to 5 percent annually the services to persons age 18 and older who are homeless with serious mental illness (SMI). **Baseline**: In FY 2004, approximately *25,263 contacts were made to persons who are homeless (*final count pending).

Rationale: During FY 2004, DMH requested that the community provider network report contacts to persons who are homeless. The provision of mental health services to persons who are homeless is an ongoing DMH system initiative.

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18-3: Increase to 5 percent annually the proportion of working-age individuals with SMI who are employed. **Baseline:** In FY 2004, 209 individuals were employed through the IPS model implementation.

Rationale: The DMH is implementing a Supported Employment Initiative. This includes the Individual Placement and Support (IPS) model as an evidence-based practice.

Focus Area 18: Mental Health and Mental Disorders -Revised 2010 Objectives with Baselines and Goals

Objective	Program	Baseline	Issues	2010 Goal
18-1.1. Expand the prevention-oriented services for children (ages 0-2) in the Parent Infant Developmen t Program in accordance with MOU with the Healthy Start Program.	DMH has a MOU with the Healthy Start Program to provide mental health services to mothers (who reside in Wards 7 and 8 who fail the depression screening) and their babies up to age 2. Two DMH social workers provide services.	In FY 2003 (Year 1), the target was 50 mothers and children. In FY 2004 (Year 2), the target was 120, and then reduced to 80. In FY 2005 (Year 3), the target remained at 80.	Two social workers each have a caseload of 40 when the target is 80. Additional resources would have to be obtained in order to increase the number of service recipients.	Prevention-oriented services have been expanded for children (0-2) in the Parent Infant Development Program in accordance with MOU with the Healthy Start Program. .

Objective		Baseline		2010 Goal
18-1.2. Expand the prevention-oriented services for children (ages 3-5) in the Therapeutic Nursery based on increased capacity.	DMH currently has the capacity to serve 20 children at one site (10 in each classroom).	Currently 14 children are being served.	The current capacity is 20, which would have to be increased in order to expand services.	Prevention-oriented services have been expanded for children (3-5) in the Therapeutic Nursery based on increased service capacity.
18-1.3. Expand the prevention-oriented services for children and adolescents (ages 5-18) in community programs by 10 percent annually.	DMH is implementing the mental health rehabilitation services (MHRS) program and certifies community-based providers to provide services to children/youth and adults that meet these standards.	In FY 2004, approximately 4,060 children were enrolled in the MHRS program, of this number 2,258 were ages 0-12, and 1,802 were ages 13-18.	The enrollment of children/youth in the MHRS program is an ongoing DMH system initiative.	Prevention-oriented services have been expanded for children and adolescents (5-18) in community programs by 10 percent annually.
18-1.4. Expand the prevention-oriented services for children in D.C. Charter and Public Schools (DCPS).	The DMH School Mental Health Program (SMHP) provides prevention, early intervention, and treatment services to students in the regular education program. This includes 11 Charter and 20 DCPS (of which there are 6 Transformation Schools).	In FY 2002, the SMHP provided mental health services to 1,722 children/youth. In FY 2003, this number increased to 3,287, and in FY 2004 to 4,221.	The provision of mental health services through the SMHP is an ongoing DMH system initiative.	Prevention-oriented services have been expanded for children in D.C. Charter and Public Schools (DCPS).

Objective		Baseline		2010 Goal
18-2. Increase to 5 percent annually the services to persons age 18 and older who are homeless with serious mental illness (SMI).	During FY 2004, DMH requested that the community provider network report contacts made to persons who are homeless.	In FY 2004, approximately 25,263* contacts were made to persons who are homeless. (* The final count is pending).	The provision of mental health services to persons who are homeless is an ongoing DMH system initiative.	The services provided to persons age 18 and older who are homeless with SMI have been increased by 5 percent annually.
18-3. Increase to 5 percent annually the proportion of working-age individuals with SMI who are employed.	The DMH is implementing a Supported Employment Initiative. This includes the Individual Placement and Support (IPS) model as an evidence-based practice.	In FY 2004, 209 individuals were employed through the IPS model implementation.	The DMH Supported Employment Initiative is an ongoing program.	The proportion of working-age individuals with SMI who are employed will be increased by 5 percent annually.

Focus Area: Sexually Transmitted Diseases *Responsible sexual behavior Is a leading health indicator.*

Overview

The mission of the Sexually Transmitted Disease (STD) Control Program is to prevent and control STDs in the District of Columbia through partnership with local communities by promoting and maintaining healthy sexual behavior. The Division of STD Control's three key strategies include: 1.) enhancing surveillance through health care providers, 2.) partnering with private and non-profit organizations to perform community health fairs and outreach activities, and 3.) raising awareness through STD educational presentations.

Issues and Trends:

Chlamydia case reports in women show a 4 percent decrease from 2,788 in year 2000 to 2,665 cases in year 2003. Screening in the STD Clinic and Family Planning Clinics is a strong contributor to the disease decline in both chlamydia and gonorrhea. Gonorrhea case reports show a 9 percent decrease from 2,712 to 2,477 cases, when comparing year 2000 to 2003, respectively. Primary and secondary syphilis reports show a 30 percent increase from 37 in 2000 to 48 case reports in 2003.

Disparities:

Since the Infertility Screening Project emphasizes screening women, chlamydia data show women ages 10 to 24, with over 70 percent of reported cases at 2,269 in year 2000, then at 2,292 in year 2003. Total chlamydia reports were 3,207 and 3,132, for years 2000 and 2003, respectively. Gonorrhea case reports show young people aged 10 to 24, are impacted with 53 percent (1,436 of 2,712) in year 2000 and 55 percent (1,372 of 2,477) for year 2003. By gender gonorrhea reports show males made up 53 percent (1,433 of 2,712) and 54 percent (1,347 of 2,477) reports for years 2000 and 2003, respectively. Primary and secondary syphilis shows a significant gender shift from 73 percent (27 of 37) year 2000 cases reports in men to 94 percent (45 of 48) among men in 2003.

Opportunities:

Prevention opportunities through community coalition partnerships, community events, and education sessions are ongoing. Hospitals, neighborhood clinics, and community-based organizations help raise STD awareness through screening and individual counseling. Community health fairs and targeted outreach events enable condom and STD literature to reach residents. STD education sessions at high schools, community groups, and a local university emphasize barrier protection, limiting sex partners, and promptly seeking health care in response to disease suspicion to reduce STDs in the District of Columbia.

Revised 2010 Objectives for Sexually Transmitted Diseases

Prevalence of Chlamydia trachomatis Infections

19-1: Reduce the prevalence of Chlamydia trachomatis infections among young people 15-24 years old in the District to no more than 3 percent. **Baseline:** The proportion of District of Columbia women testing positive for Chlamydia trachomatis infections in the STD Clinic was 7 percent (176 of 2,613) and in Family Planning Clinics 2.9 percent (106 of 3,636) in 2002.

Rationale: Pelvic Inflammatory Disease (PID) is among the most serious threats to female reproductive capability. PID is caused most frequently by Chlamydia infections and gonorrhea that ascend past the cervix into the upper reproductive tract. PID often results in scarring and either complete or partial blockage of the Fallopian Tubes (according to the federal *Healthy People 2010* 2000 edition)

The **DC Chlamydia Project** proposes to meet the 2004 prevention target of 86 cases of PID by identifying women with Chlamydia for treatment purposes. Treating these chlamydia-infected women will result in the prevention of 86 cases of PID with an estimated economic benefit of $100,362.00 ($1,167.00 per case) projected for 2004.

Incidence of Gonorrhea

19-2.1: Reduce the incidence of gonorrhea among District residents to no more than 346 cases per 100,000 population. **Baseline:** The District's gonorrhea rate was 476 per 100,000 people (calculated 2,722of 572,059 times 100,000) in 2002.

19-2.2: Reduce the incidence of gonorrhea in adolescents 10-19 years of age in the District to no more than 580 cases per 100,000 people. **Baseline: T**he gonorrhea rate among District adolescents ages 10- 19 years was 991 per 100,000 people (calculated 673 of 67,885 times 100,000) in 2002.

19-2.3: Reduce the incidence of gonorrhea in women in the District to no more than 264 cases in 100,000 population. **Baseline**: The gonorrhea rate in the District for women was 412 per 100,000 people (calculated 1,246 of 302,693 times 100,000) in 2002.

Incidence of Primary and Secondary Syphilis

19-.3: Reduce the incidence of primary and secondary syphilis in the District of no more than 3 cases per 100,000 population. **Baseline**: The primary and secondary syphilis rate in the District was 10 per 100,000 population (calculated 59 of 572,059 times 100,000) in 2002.

Rationale: The rate of spread of communicable diseases in a population is determined by three factors: (1) the rate of exposure of susceptible persons to infected individuals, (2) the probability that an exposed, susceptible person will acquire the infection (i.e., the "efficiency of transmission"), and (3) "the length of time that newly infected person remains infected and is able to spread the infection to others." Interventions can prevent the spread of an STD within a population by reducing the rate of exposure to an STD. A sustained prevention program can drive the infection to extinction in the entire population, even when these interventions are provided only to individuals and social networks with the highest rates of transmission."(Source: Anderson, 1991: The Hidden Epidemic: Confronting Sexually Transmitted. Diseases." , Thomas R. Eng and William T. Butler, editors, 1997, Institute of Medicine, National Academy of Science.)

Incidence of Congenital Syphilis

19-4: Reduce the incidence of congenital syphilis among District residents to no more than 10 cases per 1,000 live births. **Baseline:** The congenital syphilis rate in the District was 13 per 1,000 live births (calculated as 1 of 7,666 times 1,000) in 2002.

HIV- positive Rate among STD Clinic Patients

19-5: Reduce the HIV positive rate to below 1 percent among newly tested patients at the **Southeast Sexually Transmitted Diseases (STD) Clinic. Baseline**: The HIV positive rate among patients at the Southeast STD Clinic was 1.6 percent (calculated 67 of 4,032) in 2002.

Major Health Care Providers Managing STD Cases according to Treatment Guidelines

19-6: Increase to at least 98 percent the proportion of major health care providers managing STD patient care according to the most recent Centers for Disease Control and Prevention guidelines for the treatment of sexually transmitted diseases. **Baseline:** At least 97 percent (3,315 or 3,419) of major health care providers managed STD patient care according to the most recent CDC Treatment Guidelines for Sexually Transmitted Diseases in 2002.

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan,* comparable objectives are the following:
25-1: Chlamydia
25-2: Gonorrhea
25-3: Primary and secondary syphilis
25-18: Compliance with recognized STD treatment standards

Focus Area 19: Sexually Transmitted Diseases – Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
19-1. Reduce the prevalence of Chlamydia trachomatis infections among young persons 15-24 years old in the District to no more than 3 percent.	The proportion of District of Columbia women testing positive for Chlamydia trachomatis infections in the STD Clinic was 7 percent (176 of 2,613) in the STD clinic and 3 percent (106 of 3,636) in Family Planning clinics in 2002.	The prevalence of Chlamydia trachomatis is reduced to no more than 3 percent among young persons 15-24 years of age.
19-2.1. Reduce the incidence of gonorrhea among District residents to no more than 346 cases per 100,000 people.	The District's gonorrhea rate was 476 per 100,000 people (calculated 2,722 of 572,059 times 100,000) in 2002.	The incidence of gonorrhea is reduced to no more than 346 cases per 100,000 people.
19-2.2. Reduce the incidence of gonorrhea in adolescents ages 10-19 years in the District to no more than 580 cases per 100,000 people.	The gonorrhea rate among District adolescents ages 10-19 was 991 per 100,000 people (calculated 673 of 67,885 times 100,000) in 2002.	The incidence of gonorrhea in adolescents ages 10-19 years is reduced to no more than 580 cases per 100,000 people.
19-2.3. Reduce the incidence of gonorrhea in women in the District to no more than 264 cases in 100,000 people.	The gonorrhea rate in the District for women was 412 per 100,000 people (calculated 1,246 of 302,693 times 100,000) in 2002.	The incidence of gonorrhea in women is reduced to no more than 264 cases per 100,000 people.
19-3. Reduce the incidence of primary and secondary syphilis in the District to no more than 3 cases per 100,000 people.	The primary and secondary syphilis rate in the District was 10 per 100,000 people (calculated 59 of 572,059 times 100,000) in 2002.	The incidence of primary and secondary syphilis is reduced to no more than 3 cases per 100,000 people.
19-4. Reduce the incidence of congenital syphilis among District residents to no more than 10 cases per 100,000 live births.	The congenital syphilis rate in the District was 13 per 1,000 live births (calculated of 7,666 times 1,000) in 2002.	The incidence of congenital syphilis is reduced to no more than 10 cases per 1,000 live births.

Objective	Baseline	2010 Goal
19-5. Reduce the human immunodeficiency virus (HIV)-positive rate to below 1 percent among newly tested patients at the Southeast sexually transmitted diseases (STD) clinic.	The HIV-positive rate among patients tested at the Southeast STD clinic was 1.6 percent (calculated 67 of 4,032) in 2002.	The HIV-positive rate among newly tested patients at the Southeast STD clinic is below 1 percent.
19-6. Increase to at least 98 percent the proportion of major health providers managing STD patient care according to the most recent screening Centers for Disease Control and Prevention (CDC) guidelines for the treatment of Sexually Transmitted Diseases.	In 2002, 97 percent (3,315 of 3,419) of major health providers managed STD patient care according to the most recent CDC guidelines for the Treatment of Sexually Transmitted Diseases.	At least 98 percent of major health providers manage STD patient care according to the most recent CDC guidelines for the Treatment of Sexually Transmitted Diseases.

Focus Area: Substance Abuse *Substance abuse is a leading health indicator.*

Overview

Issues and Trends*:*

The District of Columbia 2000 Household Study on Substance Abuse and other extrapolations estimate that as high as 10 percent (60,000 persons) of the District population are substance users or chemically dependent. The most prevalent psychoactive substances abused in the District are as follows: 1) Alcohol; 2) Marijuana; 3) Crack Cocaine; and 4) Heroin. New or emerging drug use trends of concern include smokable PCP (known as "Dippers"), smokable methamphetamine (known as "Tina") and oral tab oxycontin abuse. The District continues to rate among the highest prevalence cities for substance abuse. The 2002 National Survey on Drug Abuse ranked the District of Columbia as the highest rated state for reported past month use of any illicit drug. This same study reports that the District had the highest rate of past year cocaine use both among persons aged 12 or older and those aged 26 or older. Substance abuse continues to be a primary cofactor to other public health maladies such as HIV/AIDS (30 percent of reported cases associated with injection drug use), drunk driving, domestic violence and tobacco related cancers and cardiovascular maladies.

Disparities:

APRA is the primary funder of the public substance abuse prevention and treatment network for indigent (uninsured or under-insured) substance abusers in the District. However, its current capacity is not sufficient to adequately fund the level of services needed. The gap in funding leaves significant gaps in services for women of childbearing age and their children and family-based treatment, as well as transitional living for homeless substance abusers enrolled or completing treatment. The primary mechanism for purchasing treatment is the "Choice in Drug Treatment" voucher system, a new initiative required by the 2000 Act (bearing the same name) passed by City Council. This system supports client choice of provider, but funding is inadequate to support the existing demand or an expanded menu of recovery support services. Therefore the primary disparity is "funding".

Opportunities:

APRA, like all public provider substance abuse agencies has recognized the need for diversifying funding streams and maximizing partnerships to increase service availability. Therefore, APRA submitted an amendment to the state Medicaid plan to include substance treatment. The approval of this amendment will significantly increase available fiscal resources. Additionally, implementation of the District statues requiring certification for treatment programs and facilities has created an opportunity for improved standards of care. The national movement toward partnerships with faith-based institutions to provide recovery support services is in line with District (APRA)

priorities. These partnerships, once funded, will markedly improve the availability of services and the integration into a true community-based approach.

Revised 2010 Objectives for Substance Abuse

Prevalence of Tobacco Use

20-1: Reduce to no more than 50 percent the proportion of youth who have ever tried cigarette smoking. **Baseline:** 55.2 percent of boys and 55.7 percent of girls have tried smoking, according to the 2003 District of Columbia Youth Risk Behavior Survey (YRBS).

Rationale: The number of District youth reported to have ever tried cigarette smoking increases daily. Nationally, each day, 3,000 youth report smoking their first cigarette.

Prevalence of Alcohol Use

20-2: Reduce to 51 percent the proportion of youth reporting they have ever drunk alcohol. **Baseline**: 66.1 percent reported drinking alcohol, according to the 2003 YRBS.

Rationale: While the drinking rates for District of Columbia high school students are below the national average (according to the CDC), prevention of alcohol use by the city's young people remains a paramount issue. The District of Columbia has the third highest per capita alcohol consumption rate in the nation, according to the *1999 Facing Fact: Drugs and the Future of Washington, DC,* issued by Drug Strategies.

Prevalence of Marijuana Use

20-3: Reduce to 20 percent the proportion of youth who have ever used marijuana. **Baseline**: 41.7 percent of youth reported using marijuana, according to the 2003 YRBS.

Rationale: Marijuana is a gateway drug and may possibly lead to use of other illicit drugs. The overall use of marijuana has decreased, however, the rate of use remains high for District students in the 12th grade. Prevention of marijuana use may lead to the prevention of additional ATOD use.

Reduction in the Number of Residents Addicted to Drugs and Alcohol

20-4: Reduce the demand for drugs and alcohol by reducing the number of residents addicted to drugs and alcohol in the District of Columbia by 25,000 by the year 2010. **Baseline:** There were 60,000 addicted residents in 2004.

Creation of a Viable Length-of Stay Social Detoxification Program for Patients with Frequent Relapses, but without Need for Medical Intervention

20-5: Create a viable length-of-stay social detoxification program to address patients who show frequent relapse patterns and do not require medical intervention. **Baseline**: There is minimal funding to support the use of other detox facilities in the District to enhance patient readiness for substance abuse treatment and to reduce the rate of recidivism.

Establishment of Partnerships for Quality Prevention and Treatment Programs

20-6: Establish coalitions and collaboratives around quality prevention programs, and youth and adult treatment programs for the addicted, including residential, outpatient, and aftercare, and special populations. **Baseline**: There were more than 20 treatment and prevention partnerships in 2004.

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan* under Goal 26, comparable objectives are the following:
26-9: Substance-free youth
26-10:Adolescent and adult use of illicit substances
26-18: Treatment gap for illicit drugs
26-21: Treatment gap for problem alcohol use
26-23: Community partnerships and coalitions

Focus Area 20: Substance Abuse - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
20-1.Reduce to no more than 50 percent the proportion of youth who have ever tried cigarette smoking.	55.2 percent of boys and 55.7 percent of girls have tried smoking, according to the 2003 District of Columbia Youth Risk Behavior Survey (YRBS).	No more than 50 percent of youth report ever having tried cigarette smoking.
20-2. Reduce to 51 percent the proportion of youth reporting that they have ever drunk alcohol.	66.1 percent reported drinking alcohol, according to the 2003 DC YRBS.	No more than 51 percent of youth report that they have ever drunk alcohol.
20-3. Reduce to 20 percent the proportion of youth who have ever used marijuana.	41.7 percent of youth reported using marijuana according to the 2003 YRBS.	No more than 20 percent of youth in the District have ever used marijuana.

Objective	Baseline	Goal
20-4. Reduce the demand for alcohol and other drugs by reducing the number of residents addicted to drugs and alcohol in the District of Columbia by 25,000 by the year 2010.	There are 60,000 addicted residents in 2004.	The demand for alcohol and other drugs in the District of Columbia has been reduced by 25,000. residents.
20-5. Create a variable length-of-stay social detoxification program to address patients who show frequent relapse patterns and do not require medical intervention.	There is minimal funding to support the use of other detox facilities in the District to enhance patient readiness for substance abuse treatment and to reduce the rate of recidivism.	A viable length-of-stay social detoxification model program has been created that serves 840 per year patients who show frequent relapse patterns and not require medical intervention on a seven to twenty-eight day schedule.
20-6. Establish coalitions and partnerships around quality prevention programs, and youth and adult treatment programs for the addicted.	There were more than 20 treatment and prevention partnerships in 2004.	Interagency, public and private partnerships around quality prevention and treatment programs are established and maintained.

Focus Area: Tuberculosis

Overview

Issues and Trends:

Issues currently challenging Tuberculosis (TB) Control's fight against TB Intervention/ elimination are successfully completing TB treatment in high-risk populations that demonstrate instability, transient tendencies, and substance *dependency* and social/psychological issues. These behaviors, in addition to the length of TB treatment (lasting at least six months), further *challenge a patient's* ability to complete recommended TB treatment.

As for trends: To date, 81 cases of TB Disease were reported in the District of Columbia for 2004; resulting in a case rate of 14.2 cases per 100,000 population. This case rate is slightly higher than the 2003 case rate (13/8 per 100,000/ 79 cases) and remains substantially higher than the 2003 national average of 5.1 cases per 100,000 population.

Disparities:

Traditionally and currently, TB in the District is reported in more men than women (74 percent vs. 26 percent in 2004), disproportionately in African Americans (73 percent of reported cases in 2004), and 22 percent of reported TB cases have HIV/AIDS.

Opportunities:

There is always a need for increased awareness of TB (risks, screening and treatment). World TB Day (March 24th), an annual event, plays a pivotal role in assisting TB Control to spread the message that TB has not been eliminated or eradicated.

Continuous interaction with area TB stakeholders increases our ability to educate residents on the symptoms, diagnosis and treatment of TB, as well as legal regulations governing TB reporting. These interactions contribute significantly to case detection, awareness-building and social mobilization regarding the symptoms, diagnosis and treatment of TB, and the importance of effective TB control. It also has the potential to significantly increase case detection rates through education, awareness-building and social mobilization.

Revised 2010 Objectives for Tuberculosis

Reduction of Incidence of Tuberculosis

21-1: Reduce the incidence of tuberculosis in the District of Columbia to no more than 9.9 cases per 100,000 population. **Baseline**: 14.3 cases of tuberculosis per 100,000 population in the District of Columbia in 2002, and for Asian/Pacific

Islanders: 0.18 cases per 100,000 population; African Americans: 10.5 cases per 100,000 population; Hispanics: 2.7 cases per 100,000 population; and American Indians/Alaska Natives: 0.18 cases per 100,000 population.

Rationale: TB is transmitted from person to person via shared airspace. Early identification and treatment of infectious TB cases will prevent transmission to other persons, decreasing the number of infected persons who may develop active (infectious) TB in the future.

Increase in Proportion of TB Patients Completing Prescribed Course of Curative Treatment

21-2: Increase to 90 percent the proportion of TB patients who complete a prescribed course of curative treatment. **Baseline**: Eighty-eight percent (88%) of patients with newly diagnosed TB disease completed a prescribed course of curative treatment within 12 months of treatment initiation in 2002.

Rationale: The mode of transmission for TB warrants the prioritization of activities, ensuring the treatment completion of infectious patients as a primary focus. This level of intervention minimizes the potential of disease transmission. Directly observed therapy (DOT) is the locally and nationally recognized method of administering TB medications.

Increase in Proportion of Close Contacts of TB Infected Patients Completing Recommended Course of Preventive Therapy

21-3: Increase to 90 percent the proportion of close contacts of persons infected with tuberculosis who complete the recommended courses in preventive therapy. **Baseline**: Less than 10 percent of close contacts of persons with active TB completed preventive therapy in 2002.

Rationale: The Division of Tuberculosis (DOT) has substantially improved treatment completion rates for TB. Close contacts of TB cases come from the same population and have the same risk factors for failure to complete recommended treatment. Level funding, thus level staffing, includes the ability to assure treatment completion via DOT for TB disease patients and close contacts.

Comparable National 2010 Objectives

In the federal *Healthy People 2010 Plan*, comparable objectives are the following:
14-11: Tuberculosis
14-12: Curative therapy for tuberculosis

Focus Area 21: Tuberculosis - Revised 2010 Objectives with Baselines and Goals

Objective	Baseline	2010 Goal
21-1. Reduce the incidence of tuberculosis in the District of Columbia to no more than 9.9 cases per 100,000 population.	14.3 cases of tuberculosis per 100,000 people in the District of Columbia in 2002, and - For Asian/Pacific Islanders: 0.18 cases per 100,000 population in the District in 2002; - For African Americans: 10.5 cases per 100,000 population in the District in 2002; - For Hispanics: 2.7 cases per 100,000 population in the District in 2002; and - For American Indians/ Alaska Natives: 0.18 cases per 100,000 population in the District in 2002.	The incidence rate of tuberculosis in the District of Columbia is no more than 9.9 cases per 100,000 population, and - For Asian/Pacific Islanders: 0.18 cases per 100,000 population; - For African Americans: 10 cases per 100,000 people; - For Hispanics: 2.3 cases per 100,000 population: and - For American Indians/ Alaska Natives: 0.18 cases per 100,000 population.
21-2. Increase to 90 percent the proportion of TB patients who complete a recommended course of curative treatment.	Eighty-eight percent (88%) of patients with newly diagnosed TB disease completed a prescribed course of curative treatment within 12 months of treatment initiation in 2002.	90 percent of reported TB patients will complete a recommended course of curative treatment within a 12 month period.
21-3. Increase to 90 percent the proportion of close contacts of persons infected with TB who complete the recommended courses in preventive therapy.	Less than 10 percent of close contacts of persons with active TB completed preventive therapy in 2002.	90 percent of close contacts of persons infected with TB complete preventive therapy.

NOTES

For more information, contact the Healthy People 2010 Plan Coordinator at State Center for Health Statistics Administration of the Department of Health at (202) 442-9039.